CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

KP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A.	B.	C.	D.
[ ] Establish retention period for records which are accumulating daily.	[ ] Dispose of present accumulation, no additional accumulation anticipated.	[ ] Microfilm and destroy originals.	[X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B.	C.
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

XP 23907

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21—M&T—1500 Bks.

D 63258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63258

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2828 Montebello Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Cummings

(a) RESIDENCE NO. 2828 Montebello Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Myrtle Cummings

6 DATE OF BIRTH (month, day, and year) Aug 24-80

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Himself 850

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Michael Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Myrtle Cummings (Address) 2828 Montebello Ave

15 APR 8 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany, 1922 to April 5, 1922

that I last saw h alive on April 4, 1922

and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J Kovak M. D.

April 7, 1922 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 4/8 1922

20 UNDERTAKER Philip Henry — ADDRESS 2016 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK. This is a Permanent Record. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63259

D 63259

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 57 Madfelt ave ST., 27 WARD)

2-FULL NAME Matilda Imhoof

(a) RESIDENCE No. 57 Madfelt ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Imhoof

6 DATE OF BIRTH (month, day and year): Dec 4 1860

7 AGE: Years 61 Months 4 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): MD

PARENTS

10 NAME OF FATHER: John L. B. Cramlet

11 BIRTHPLACE OF FATHER (city or town) (State or country): MD

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: George Imhoof

(Address)

15 Filed , 19

Registrar

R 1 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1922 to April 7 1922

that I last saw her alive on April 7 1922

and that death occurred, on the date stated above, at 9 15 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C F Knipple, M. D.

April, 19 22 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Apl 10 1922

20 UNDERTAKER: Chenoweth & Son — ADDRESS: Chestnut Ave

Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63260

74-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S. Wolfe ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Birch.

(a) RESIDENCE. No. 309 S. Wolfe ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James B. Birch.

6 DATE OF BIRTH (month, day, and year): July 15th 1873

7 AGE — Years: 48 — Months: 9 — Days: 6 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): at Home. 137

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Matthew Stapleton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Johanna Troy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informan. (Address): James B. Birch 309 S. Wolfe St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1922, to April 6, 1922, that I last saw h[illegible] alive on April 6, 1922, and that death occurred, on the date stated above, at 2 35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary): arteriosclerosis.

(duration) yrs. [illegible] mos. [illegible] ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy? X

What test confirmed diagnosis? X

(Signed) Frank J. Lamb M. D.

4/6, 1922 (Address) 2431 Fait Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: April 10 1922

20 UNDERTAKER: Lilly Zeiler — ADDRESS: 408 S. Wolfe

Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63261

100-001

100-D 63261

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 300 S. Twelfth St.: 76 WARD)

2-FULL NAME Ruth Miller

(a) RESIDENCE. NO. 300 S. Twelfth ST. 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15.	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar at

(b) General nature of industry, business, or establishment in which employed (or employer) School (H)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa.

PARENTS

10 NAME OF FATHER Bernard Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ines. Marbel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Ines. Miller (Mother)

(Address) 300 S. 12th St.

15 Filed ....., 19..... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to April 6, 1922, that I last saw her alive on April 5, 1922, and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Broncho. pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Charles L Cook, M. D.

4/6. 1922 (Address) 503 S. Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: April 10th 1922

20 UNDERTAKER: Lilly & Zeller

ADDRESS: 403 S. Hoyd St

8-1922

MAKE ENTRIES be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63262

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bridget A Ball

(a) RESIDENCE NO. 33 Bloomsbury Ave (St.) Portland (WARD) Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Husband

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1861

7 AGE: Years 60 yrs | Months 7 | Days 7 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Not any

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Martin Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr. James F. Ball

(Address) 33 Bloomsbury Ave

15 Filed ..... 19 ..... Robert E. Lantz, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1922, to April 7, 1922

that I last saw he alive on April 7, 1922

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Patient was admitted to hosp with pneumonia but died of pneumonia hyp[ostatic]

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? St Agnes Hosp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J C Caldwell, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: April 10 1922

20 UNDERTAKER: Eaton Son

ADDRESS: Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R - 81977

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63263

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Jordan ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Adams

(a) RESIDENCE. NO. 922 Jordan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 26 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Richard Thos. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Fannie Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Fannie Adams (Address) 922 Jordan Alley

15 Filed 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1922, to April 6, 1922, that I last saw her alive on April 6, 1922, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

Possibly due to fatty diet

(duration) — yrs. — mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelletreau, M. D.

, 19 (Address) 817 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 8 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Ashland Av

1 - 81922

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HAWKINS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63264

CERTIFICATE OF DEATH.

D 63264

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1401 Patapsco ST., 23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie C. Hawkins

(a) RESIDENCE NO. 1401 Patapsco ST., 23. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 7/5/1919

7 AGE Years 2 Months 9 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillian Ruling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Edward Jones 1401 Patapsco st.

15 Filed 19 Robert F. Norriss, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1922

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1922, to April 8, 1922, that I last saw her alive on April 7, 1922, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar Congestion

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diphtheria (Laboratory)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Dr. Thos. Jones, M. D.

4/8, 1922 (Address) 16 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern Cem

DATE OF BURIAL 4/9 1922

20 UNDERTAKER Jno. F. Lahey & Sons

ADDRESS 13 Eight St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Q - 8 1922

Spec.—8-24-14—M. & T.—2000 Bks.

D 63265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63265

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1146 Hull St.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marzinek, Frank

(Residence in Baltimore: No. 1146 Hull St.; yrs., 4 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, November 21, 1911.
(Month) (Day) (Year)

7-AGE, yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jachek Marzinek

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Wladeslawa Jachek

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Brook M.D.

(Address) 2202 North Av.

15-

Filed ....., 191.....

Robert J. Garrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7th, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-29-1912, to 4-7-1912, that I saw h alive on 191, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) yrs. 4 mos. ds.

(Signed) H. Brook M. D.

4-8-, 1912 (Address) 2202 N. North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross DATE OF BURIAL, April 1912

20-UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8922

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63266

CERTIFICATE OF DEATH

101 D 63266

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1312 Towson St. St. 11th WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Helen Rhubes

(Residence in Baltimore: No. 1312 Towson St. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 8, 1921 (Month) (Day) (Year)

7 AGE: 1 yrs. mos. 30 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Balto md

PARENTS

10 NAME OF FATHER: James Rhubes

11 BIRTHPLACE OF FATHER (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Sophia Kohl

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Rhubes

(Address) 1312 Towson

15 Robert P. Harrison,

Filed ..., 191

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 7, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 3, 1922 to Apr. 7 1922, that I saw her alive on Apr. 6, 1922, and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Thos Fa Stevens M. D.

4/7/ 1922 (Address) 2878 Hanford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross Cem Cad

DATE OF BURIAL: Apr 10 1922

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St.

B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4-8 1922

Spec.—1-10-21—M&T—1500 Bks.

D 63267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63267

100'001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Jackson ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Voit

(a) RESIDENCE NO. 1701 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
		2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Adolph Voit

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sophia Muckwitz

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Adolph Voit.
(Address) 1701 Jackson Ave

15 1922 Robert P. Harrison, 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1922

17

I HEREBY CERTIFY, That I attended deceased from Apr. 2nd 1922 to Apr. 7 1922,

that I last saw him alive on Apr. 7 1922,

and that death occurred, on the date stated above, at 10 45P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Symms, M. D.

4/8, 1922 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Cem

DATE OF BURIAL Apr 9 1922

20 UNDERTAKER Margaret S. Flynn

ADDRESS 1422 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63268 D 63268

HEALTH DEPARTMENT—CITY OF BALTIMORE

63268 D 63268

CERTIFICATE OF DEATH.

REGISTERED NO. 4

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 226 Amity ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harriday

(a) RESIDENCE. No. 226 Amity ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 74 mos. ds.

MATION SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colard	married

5a If married, widowed, or divorced HUSBAND of Husband (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
74				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Whitewasher 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Perry Harriday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Hattie Harriday

(Address) # 226 Amity

15 Filed APR 9 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1922

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1922, to April 6, 1922, that I last saw h[illegible] alive on April 6, 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John Casey M. D.

, 19 (Address) 23 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	4-10-1922
20 UNDERTAKER	ADDRESS
Robert E. Williams	1106 Ashland ave

Spec.—8-24-14—M. & T.—2000 Bks.

63269 HEALTH DEPARTMENT—CITY OF BALTIMORE 63269

D 63269 CERTIFICATE OF DEATH. 90 D 63269

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1542 N. Stricker ST.; 15 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Henry Schaeffer

(Residence in Baltimore: No. 1542 N Stricker St. St.; ....yrs. ....mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 6th (Day), 1848 (Year)

7-AGE, 73 yrs. 11 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Stone mason (b) General nature of industry, business, or establishment in which employed (or employer) 675

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Geo. H. Schaeffer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Roland

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Margaret Schaeffer

(Address) 1542 N. Stricker St

15- FILED APR 9 - 1922 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 27 1921, to Apl 6 1922, that I saw h[illegible] alive on Apl 8" 1922, and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

Due to Coronary Sclerosis

(Duration) A few Minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

About 2 (Duration) yrs. mos. ds.

(Signed) O. H. Duvall M. D.

Apl 6, 1922. (Address) 1817 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Cemetery

DATE OF BURIAL, April 10, 1922

20-UNDERTAKER E. J. Fanning & Son - 1923 E Lafayette

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63270

CERTIFICATE OF DEATH.

100 D 63270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 E. Church ST. W WARD)

2-FULL NAME Samuel Melvin Wright

(a) RESIDENCE. NO. 19 E. Church ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/29/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none pds

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Matthews (Wright)

11 BIRTHPLACE OF FATHER (city or town) Oxford (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mary E. Brooks
(Address) 37 E. Church St.

15 APR 9 - 1921 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6 1921

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1921, to Apr 6, 1921, that I last saw him alive on Apr 6, 1921, and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Earl Arnold, M. D.

4/7 1921 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn, DATE OF BURIAL April 9 1921

20 UNDERTAKER J. L. Bivens Son ADDRESS 108 North

Make should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection present.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63271

CERTIFICATE OF DEATH.

X 84

D 63271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2353 Eutaw Place ST., 13 WARD)

2-FULL NAME Simon Rosenbaum

(a) RESIDENCE NO. 2353 Eutaw Place ST., WARD Cumberland Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rickla Rosenbaum

6 DATE OF BIRTH (month, day, and year): Oct 31st 1846

7 AGE — Years: (75) 75 — Months: 5 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Ingrahant 045
(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Isaac Rosenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germ

14 Informant (Address): Mr Rosenbaum 2353 Eutaw Place

15 Filed APR 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to April 8, 1922, that I last saw h in live on April 8, 1922, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Angina-De Poris

(duration) — 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) 10 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Cumberland Md.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) J. W. Kelly M. D.

19 (Address) 2327 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md — DATE OF BURIAL: April 9th 1922

20 UNDERTAKER: Wm Rondheim — ADDRESS: 118 W. mt. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

154/90 D 63272 — D 63272 — 31

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME William Hall

(a) RESIDENCE NO. 840 N. Chester ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 15th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Hall

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Kaminski

13 BIRTHPLACE OF MOTHER (city or town) Buffalo (State or country) N.Y.

14 Informant (Address) JOHNS HOPKINS HOSPITAL Arcade

15 Filed APR 9 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch. 27th, 1922 to April 8th, 1922, that I last saw h[illegible] alive on April 8th, 1922 and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Lumbar puncture.

(Signed) Horace G. Stewart, M. D.

4/8, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Apr 19 22
20 UNDERTAKER	ADDRESS
Wendell Dyer & Son	324 N.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 63273

D 63273

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 212 E. Caroline ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Wagner

(a) RESIDENCE NO. 212 E. Caroline St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Wagner

6 DATE OF BIRTH (month, day, and year) Nov. 10. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegrapher Operator 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine Wagner

(Address) 212 E. Caroline St.

15 Filed APR 9 - 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1922

17 I HEREBY CERTIFY, That I attended deceased from March 26. 1922. to April 8. 1922.

that I last saw him alive on April 7. 1922.

and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Spinal Sclerosis (Ascending)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gradual loss of power in legs

(Signed) Charles O'Donovan, M. D.

4-9, 1922 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem.

DATE OF BURIAL 4/11/22 19

UNDERTAKER Windsor Duffy & Sons

ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63274

CERTIFICATE OF DEATH.

D 63274

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Aisquith St.; 5 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Chaney

(a) RESIDENCE. No. 207 Aisquith St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): 1839

7 AGE: Years 83; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Montgomery Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lizzie Chaney

(Address) 1238 E. Lanvale St

15 Filed APR 9 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 8 1922

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1922, to Apr 8, 1922, that I last saw h[illegible] alive on Apr 7, 1922, and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

10 days (duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher, M. D.

4-8 1922 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Frederick

DATE OF BURIAL: Apr 10 1922

20 UNDERTAKER: George H. Holland

ADDRESS: 1631 Druid Hill Ave

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 63275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514-S. Pulaski ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Friedman,

(a) RESIDENCE NO. 514-S. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. one mos 10 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar. 1-1922.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
—	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 100

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Benj. Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Rep. Benj. Friedman 514 S. Pulaski St

15 Filed APR 9-1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8- 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 6-, 1922, to April 8, 1922.

that I last saw her alive on April 8-, 1922,

and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary): None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan B Budensky, M. D.

4/8, 1922 (Address) 2114 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hebron Cem Co

DATE OF BURIAL: 4/9 1922

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore St

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63276

CERTIFICATE OF DEATH.

D 63276

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 Wilkins av ST.: 70 WARD)

2-FULL NAME Howard C Laage

(a) RESIDENCE. NO. 2233 Wilkins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 11 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Conrad L. Laage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Florence Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant C L Laage (Address) 2223 Wilkins av

15 Filed APR 9 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 4 19 22, to April 8, 19 22, that I last saw h[illegible] alive on April 7, 19 22, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo Linkiffen M. D.

April 8 19 22 (Address) Morrell Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Apr. 9 19 22

20 UNDERTAKER: Geo. L. Schwab — ADDRESS: Woodbine Md.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH D 63277

109-00X V

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Registration Dist. No. D 63277

Village or City Baltimore, (No. 704, Augusta Ave St.; 20th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Melvin Leo Steinfeet

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH: May (Month) 14 (Day), 1894 (Year)

7 AGE: 78 yrs. 10 mos. 27 ds. If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION
(a) Trade, profession or particular kind of work: Accountant 659
(b) General nature of industry, business, or establishment in which employed or (employer): American Ag. Chem Co

9 BIRTHPLACE (State or country): Baltimore -

PARENTS

10 NAME OF FATHER: Henry J. Steinfeet

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Julia E. Walter

13 BIRTHPLACE OF MOTHER (State or country): Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Harry Steinfeet

(Address)

15 Filed APR 9 - 1922, 192 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 7th (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 4 1922, to April 7th, 1922, that I last saw h m alive on April 7th, 1922, and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral infection Tonsilo

(Duration) yrs. mos. 5 ds.

Contributory Secondary: Cardiac Embolism

(Duration) yrs. 1 or 2 mos. ds.

(Signed) Robert V. Leuther M. D.

April 8. 1922 (Address) Relay - Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State, 78 yrs. 10 mos 27 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park | DATE OF BURIAL: Apr. 9, 1922

20 UNDERTAKER: Geo. A. Schwab | ADDRESS: 600 Park Ave

If more blanks are needed, address State Registrar. 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63278

CERTIFICATE OF DEATH.

101-001 D 63278

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2451 McCulloh St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Fraker

(Residence in Baltimore: No. 2451 McCulloh St.; 69 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) April (Day) 1 (Year) .....

7-AGE, 31 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER Robert H. Fraker

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Elizabeth Merry

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Easton

(Address) 916 Pa Ave

15-

Filed APR 9 - 1922, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 6 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1922, to April 6 1922, that I saw h.. alive on April 6 1922 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

.....

.....

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) ..... M. D.

April 8, 1922 (Address) 752 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence R

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem

DATE OF BURIAL, April 9, 1922

20-UNDERTAKER David Easton

ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63279

CERTIFICATE OF DEATH.

D 63279

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3419 (St.) Claremont Ave (WARD) 26

2-FULL NAME. Rosina Kimble

(a) RESIDENCE NO. 3419 (St.) Claremont Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Widow of Herman Kimble

6 DATE OF BIRTH (month, day, and year): Jan 31 1840

7 AGE — Years: 81 — Months: 2 — Days: — If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Kumpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Catherine Rumpf

(Address) 3419 Claremont Ave

15 FILED APR 9 - 1922 ROBERT R. KRAUTER, Registrar

Treas. 3rd Bank of Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 8, 1922

that I last saw her alive on April 8, 1922

and that death occurred, on the date stated above, at 3 30a m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

Arteriosclerosis

(duration) 2 yrs. X mos X ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) X yrs. X mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? .....

What test confirmed diagnosis? None

(Signed) Jas. L. Tyson M. D.

April 8, 1922 (Address) 248 St 3054

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Harford Rd — DATE OF BURIAL: April 11, 1922

20 UNDERTAKER: William Oakes — ADDRESS: 502 E North Ave

INSTRUCTIONS. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63230 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 57 D 63280

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST., 26 WARD)

2-FULL NAME Wm Hartman

(a) RESIDENCE NO. 11 N Bentalou ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Hartman

6 DATE OF BIRTH (month, day, and year) 2-3-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Ottis Worthington

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Eleanor Dorsey

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Self (Mrs Hartman)
(Address) 11 N Bentalou

15 Filed APR 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/2/22, 19....., to 4/8/22, 19.....,

that I last saw h[illegible] alive on 4/8/22, 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

My Cerebellar Ataxia Resulting in Paralysis of Respiratory Muscles

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? Clinical Findings

(Signed) J. A. Campbell Neil, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harmony Cemetery — DATE OF BURIAL 4/11 1922

20 UNDERTAKER Wellington Cook — ADDRESS 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63281

CERTIFICATE OF DEATH.

D 63281

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kunkle

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 3/1/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	0-	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 APR 9 - 1922 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from March 21 1921 to April 7 1922

that I last saw h er alive on April 6 1922

and that death occurred, on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

Hypopituitrism

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Pyelitis. (duration) yrs. mos. 3 ds.

If there was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Clyde McNeill, M. D.

4/7/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	4/10
20 UNDERTAKER	ADDRESS
W. P. Cook Co.	502 E. Nan

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63282

133 D 63282

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1723 E 33 rd St., 9 WARD)

2-FULL NAME Catherine E Lindsay

(a) RESIDENCE No. 1723 E 33rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Widow of Granville Lindsay

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: 62 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William S Gaston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: M Gertrude Lindsay (Address): 1723 E 33rd St

15 Filed APR 9 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-8 1922.

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1922, to 4-8, 1922, that I last saw her alive on 4-8, 1922, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Oedema

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Cystitis - Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observations

(Signed) J J Roberts, M. D.

, 19 (Address) 461 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Cemetery — DATE OF BURIAL: 4/11 1922

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

ROBERT R. KRAUTER, Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63283

CERTIFICATE OF DEATH.

179 D 63283

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3128 Harford ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel F Smith

(a) RESIDENCE NO. 3128 Harford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or Wife of~~ Martha A Smith

6 DATE OF BIRTH (month, day, and year) December 28th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coach Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) Elkridge
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) ~~Anna S Dicus~~

12 MAIDEN NAME OF MOTHER Anna S Dicus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Martha A Smith
(Address) 3128 Harford ave

15 Filed APR 9 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch 1st, 1922, to April 8th 1922.

that I last saw ~~him~~ alive on Apl. 8th 1922,

and that death occurred, on the date stated above, at 4.55 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. 9. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robert S. Kirk, M. D.

(Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL April 11th 1922

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63284

CERTIFICATE OF DEATH.

100-001

D 63284

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1614 Patapsco St. ST.: 23 WARD)

2-FULL NAME Katharine May Bradley

(a) RESIDENCE. NO. 1614 Patapsco St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James L. Bradley

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mamie C. Kepper

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Mrs. James L. Bradley
(Address) 1614 Patapsco St.

15 Filed APR 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to April 8, 1922, that I last saw h.e.r alive on April 8, 1922, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell, M. D.

April 8, 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 4/10 1922

20 UNDERTAKER D. Frew McCully

ADDRESS 130 E. Fort

ROBERT N. KRESS
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63285

D 63285

CERTIFICATE OF DEATH.

REGISTERED NO. 15 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 N. Monroe St. ST.: WARD) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schmeltz

(a) RESIDENCE. NO. Jessop's Md. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Schmeltz

6 DATE OF BIRTH (month, day, and year) Aug. 5 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

37

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Frederick Korte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John W. Schmeltz
(Address) Jessop's Md.

15 Filed APR 9 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 7, 1922, that I last saw her alive on April 6, 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) no yrs. no mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) R. Ryglewicz, M. D.

April 7 1922 (Address) Lakeland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pfeiffer's Corner Cem. Jessops	4/10 1922
20 UNDERTAKER J. Few McCully	ADDRESS 130 E. Ford.

INSTRUCTIONS.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63286

D 63286

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 E Lombard ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Lipsitz

(a) RESIDENCE NO. 1117 E Lombard St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gutman

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 85; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Lazarus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Rosa Holsweig

(Address) 1117 E Lombard St

15 Filed APR 9 - 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922 to April 8, 1922.

that I last saw her alive on April 8, 1922

and that death occurred, on the date stated above, at 6 h m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture of hip

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Gaylin, M. D.

4/9, 1922 (Address) 210 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hunting Run — DATE OF BURIAL 4/9 1922

20 UNDERTAKER: Max Levinson — ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall
- down step.
No Felony.
C. C. Blades M.D.
Coroner at Large.

Spec.—1-10-21—M&T—1500 Bks.

D 63287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63287

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry D. Hilderbrandt

(a) RESIDENCE NO. ..... ST. ..... WARD Mt. Vernon, Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Isadee Hildebrandt

6 DATE OF BIRTH (month, day, and year) Sept. 16-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanical Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer) 130

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER T. J. Hildebrandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jane Daniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL Record

15 APR 9 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8th 1922

17

I HEREBY CERTIFY, That I attended deceased from MARCH 9, 1922, to APRIL 8, 1922,

that I last saw him alive on APRIL 7, 1922,

and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

ANGINA PECTORIS

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del — DATE OF BURIAL APR 8 1922

20 UNDERTAKER Geo. W. Little ADDRESS 3700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63288

CERTIFICATE OF DEATH.

Registered No. C..... D 63288

1-PLACE OF DEATH

City of BALTIMORE: (No. #2102-N-Calvert-St. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ISABELLE CLARK

(Residence in Baltimore: No. #2102-N-Calvert-St. (12-Ward) St.; yrs.,.....mos.....ds.) (1-Day)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. About-------1855
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
Abt-67 yrs. ? mos. ? ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Tremont, Maine.

PARENTS.

10-NAME OF FATHER, Eaton Clark

11-BIRTHPLACE OF FATHER, (State or Country). Mt. Desert, Maine.

12-MAIDEN NAME OF MOTHER, Julia A.S.Babson.

13-BIRTHPLACE OF MOTHER, (State or Country). Mt. Desert, Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Geo. F. Clark (nephew)

(Address) Room-903-B. & O. Bldg., City.

15- ROBERT R. KRAUTER,
Filed APR 9 - 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to.....Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

1922 (Address) 5632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 0 yrs. 0 mos. 1 ds. In the State 0 yrs. 0 mos. 1 ds.

Where was disease contracted, if not at place of death? #2102-N-Calvert-St.

Former or usual residence. Tremont-Maine.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Tremont, Maine.	April-9-22 19

20-UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	108 W. NORTH AVE.

IMPORTANT—CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

63289 D 63289

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 63289 D 63289

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1116 N. Fulton Ave ST.: ... 16th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Sidney Osborne

(Residence in Baltimore: No. 1116 N. Fulton Ave St.; 13 yrs. 11 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Port Nls. Point July 14 (Month) (Day) 1837 (Year)

7-AGE: 84 yrs. 10 mos. — ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Laborer 086
(b) General nature of industry, business, or establishment in which employed (or employer): Topographical Survey City of Baltimore

9-BIRTHPLACE (State or country): Port Nelson, Md.

PARENTS

10-NAME OF FATHER: Thos. H. Osborne

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Adalisa White

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE:

(Informant) Leonard W. Osborne

(Address) 1116 N. Fulton Ave

15- Filed APR 10 1922, 191 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from several years, 191..., to, apl 9 1922, that I saw h... alive on 9th apl 1922, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

General debility &
paresis

(Duration) ... yrs 1½ mos. ... ds.

Contributory (SECONDARY) Exhaustion

(Duration) ... yrs ... mos. 4 ds.

(Signed), Barnett A. Bailen M. D.

4/9 1922 [Address] 1404 Linden Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Abington Md. DATE OF BURIAL: April 11th, 1922

20-UNDERTAKER: W. W. Irwin ADDRESS: 918 Edmondson Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63290
D 63290

HEALTH DEPARTMENT—CITY OF BALTIMORE

63290

CERTIFICATE OF DEATH.

31 D 63290

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Glyndon Av ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W. Kral Jr.

(a) RESIDENCE. NO. 1329 Glyndon Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Muriel Kral

6 DATE OF BIRTH (month, day, and year): Sept. 10, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: pipefitter 059

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: American Oil Co.

9 BIRTHPLACE (city or town) (State or country): Balto. County Md.

PARENTS

10 NAME OF FATHER: Frank W. Kral Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mary Sadelick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant (Address): 1329 Glyndon ave Frank W. Kral Sr.

15 Filed: APR 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1922, to April 7, 1922, that I last saw h[e] alive on April 6, 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum test positive

(Signed) J. M. Elwell, M. D.

1922 (Address) 621 Columbia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 10 1922
20 UNDERTAKER: Lew Leinbach & Son	ADDRESS: 6 Orem Pl.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63291

CERTIFICATE OF DEATH.

3 | D 63291

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Oxford St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell Tait

(Residence in Baltimore: No. 503 Oxford St.; 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, (Month) (Day) 1894. (Year)

7-AGE, 28 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Robt Tait

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Jennie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Friendship Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Tait

(Address) 503 Oxford St

15-

Filed APR 10 1912 191 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7 (Month) (Day) 1912 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1912, to April 8 1912, that I saw h alive on April 7 1912, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. 2 mos. ds.

(Signed) J Woodward M. D.

(Address) 939 or Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, April 10 1912

20-UNDERTAKER Burns Freeland & Schwabert

ADDRESS 1114 W

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Burrows.

D 63292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63292

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ... ST., No ... WARD)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Burrows

(a) RESIDENCE NO. ... ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown.

6 DATE OF BIRTH (month, day, and year): 1842

7 AGE — Years: 80 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Do

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bay View Hospital Balto, Md

15 APR 10 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922 to April 8, 1922

that I last saw him alive on April 8, 1922

and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Terminal)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith M. D.

4/9/1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star Cem.

DATE OF BURIAL: April 10, 1922

20 UNDERTAKER: Edw W. Pyse

ADDRESS: 713 Edmondson Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Becker

HEALTH DEPARTMENT—CITY OF BALTIMORE

63293

CERTIFICATE OF DEATH.

D 63293

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3803 Fernwood ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Becker

(Residence in Baltimore: No. 3803 Fernwood St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 29 (Day), 1846 (Year)

7-AGE, 76 yrs. 4 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book-Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Wood

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Fred C. Becker

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Becker

(Address) 3803 Fernwood Ave

15-

Filed....., 191... ROBERT R. ..., Burial Permit Clerk,

APR 10 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1921, to April 7 1922, that I saw him alive on April 7 1922, and that death occurred, on the date stated above, at 7:45 m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

April 8, 1922 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, Apr. 10th 1922

20-UNDERTAKER Joseph D. Cook — ADDRESS 1003 N Bals St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63294

CERTIFICATE OF DEATH.

100 D 63294

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital (ST.:) 3 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Harris Carmel

(a) RESIDENCE. No. 1439 Gough St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Carmel

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor. 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Carmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanny Carmel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jews [illegible] (Address) 1439 E. Gough St

15 APR 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9. 1922

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1922, to April 9, 1922, that I last saw him alive on April 9, 1922, and that death occurred, on the date stated above, at 10.15 a m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) [illegible] M. D.

4/8, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Hebrew Hebrew Rest — DATE OF BURIAL 4/10 1922

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Gough St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63295

HEALTH DEPARTMENT—CITY OF BALTIMORE

001
101 D 63295

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1753 Orleans ST., 6 WARD)

2-FULL NAME Beckie Bernstein

(a) RESIDENCE No. 1753 Orleans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	[redacted]

5a If married, widowed, or divorced (or) WIFE of [redacted]

6 DATE OF BIRTH (month, day, and year) ---------1980

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [redacted] Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant [redacted] Bernstein

(Address) 1753 Orleans St.

15 APR 10 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 9 - 1922

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1922, to April 9, 1922,

that I last saw her alive on April 9, 1922,

and that death occurred, on the date stated above, at 8-30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) - yrs. - mos 3 ds.

CONTRIBUTORY (Secondary) cardiac failure

(duration) yrs. - mos. 1 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) M. N. Putterman, M. D.

, 19 (Address) 1627 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cem

DATE OF BURIAL 4/10 1922

20 UNDERTAKER Jack Lauris 1439

ADDRESS E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

63296 HEALTH DEPARTMENT—CITY OF BALTIMORE 63296

CERTIFICATE OF DEATH.

REGISTERED NO. 15-74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Norwood Avenue, ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DOROTHY A. FARLEY,

(a) RESIDENCE. No. 1601 Norwood Avenue, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of MICHAEL J. FARLEY

6 DATE OF BIRTH (month, day, and year) June 30th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER DANIEL MAKISON,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER LINA JOHANNES,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Michael J. Farley 1601 Norwood ave

15 Filed APR 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from January 18th 1922 to April 7th, 1922, that I last saw her alive on April 5th, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) - yrs. - mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 5 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Paysical examination

(Signed) Edw. M. Longwell, M. D.

4/8. 1922 (Address) 5 N. Washington Street,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: April 10 1922

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Hartford ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63297 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63297

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bellwood Ave & Harford Rd. WARD) 47

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosemary May Gallagher

(a) RESIDENCE. No. Bellwood Ave & Harford Rd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day and year) May 16-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant nil

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Hamilton Balto Md

PARENTS

10 NAME OF FATHER James J. Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Shinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant J. J. Gallagher

(Address) Hamilton Balto Md.

15 Filed APR 10 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit C[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 8, 19 22, to April 8, 19 22,

that I last saw h[illegible] alive on April 8, 19 22,

and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows:

Respiratory Paralysis
(Convulsions)

(duration) — yrs. — mos. 2 hours ds.

CONTRIBUTORY (Secondary) Gastro-Intestinal Toxemia

(duration) — yrs. — mos. 6 hours ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

4/10 1922 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 4/10 1922

20 UNDERTAKER: Geo J Ruth

ADDRESS: 1735 Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63298

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63298

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 428 Twenty Second St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hall.

(Residence in Baltimore: No. 428 Twenty Second St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.): Widowed

6-DATE OF BIRTH: January 15th 1851
(Month) (Day) (Year)

7-AGE: 71 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: John Harrison.

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Smith.

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josefe Hall.

(Address) 428 Twenty Second St.

15-

Filed APR 10 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. dilat. heart

(Duration) ....yrs.....mos.....ds.

Delirium, Edema.

CONTRIBUTORY (Secondary)

(Duration) ....yrs.....mos.....ds.

(Signed) H. L. Riley M. D.
(Coroner.)

Apr. 9 1922 (Address) 1639 Eutaw

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peter Cemtery.	April 10 1922
20-UNDERTAKER,	ADDRESS
George F. Rutt.	1735 Hayford Ave

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63299

CERTIFICATE OF DEATH.

100-001 D 63299

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 18 E 22nd St (St.) 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Taylor Woodward

(a) RESIDENCE. No. 18 E 22nd St St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIDOW~~ of: Alma McNeill Woodward

6 DATE OF BIRTH (month, day, and year): March 19 1860

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Vice President

(b) General nature of industry, business, or establishment in which employed (or employer): Baby Furniture Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Dr Richard H Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Susan Pollard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Alfred Bagley Jr

(Address) 111 St Charles St

15 FILED: APR 10 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1922, to April 9th, 1922, that I last saw him alive on April 8th, 1922, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Casey B Tramell Jr, M. D.

, 19 (Address) 240 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 10 1922
20 UNDERTAKER	ADDRESS
Henry W Jenkins Son Co	Richard & McCulloh Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63300

CERTIFICATE OF DEATH.

129

D 63300

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1018 Aisquith ST., 10 WARD)

2-FULL NAME Louisa C. Sweeney

(a) RESIDENCE NO. 1018 Aisquith ST., 10 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced (or) WIFE of: George H. Sweeney

6 DATE OF BIRTH (month, day, and year): not known

7 AGE — Years: 65 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James J. Jeffers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Annie Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Md

14 Informant: Mr. George H. Sweeney

(Address) 1018 Aisquith St

15 Filed APR 10 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from March 17th, 1922, to Apr 9th, 1922, that I last saw h[illegible] alive on Apr 8th, 1922, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Arrested

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) L. M. C. Parker M. D.

Apr 10, 1922 (Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Apr. 12 1922

20 UNDERTAKER: Henry Hoeck Low — ADDRESS: 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63301

CERTIFICATE OF DEATH.

7/601

D 63301

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS H SPT. L St., 9 WARD)

2-FULL NAME Catharine Curry

(a) RESIDENCE NO. 605 N. Caroline St. City:

(Usual place of abode) WARD .....

Length of residence in city or town where death occurred ... yrs. 7 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Enoch & Grace Curry parents

6 DATE OF BIRTH (month, day, and year): Oct 7, 1914

7 AGE — Years | 6 Months | 1 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Enoch Curry

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Grace Keightley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant: JOHNS HOPKINS H SPT L (Address) Dead

15 FILED APR 1 0 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to April 9, 1922, that I last saw her alive on April 9, 1922, and that death occurred, on the date stated above, at 2 10 A. m.

The CAUSE OF DEATH* was as follows:

Meningitis, acute, purulent (Etype unknown) 000

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Obstruction hydrocephalus unknown

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Semiology & autonomic punctures

(Signed) Horace G. Stewart, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: April 10 1922

20 UNDERTAKER: Thos J. G. Locke

ADDRESS: 532 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acquired hydrocephalus

Organism unknown

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63302

CERTIFICATE OF DEATH.

179 D 63302

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Baker ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Smith

(a) RESIDENCE NO. 1631 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jefferson W. Smith

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE: Years 66; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Fredericksburg Va.

PARENTS

10 NAME OF FATHER: Wm Shelton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: William P. Smith

(Address): 1623 N. Carey St.

15 Filed APR 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Apl. 1. 1922, to Apl. 8. 1922, that I last saw h[illegible] alive on Apl 8. 1922 and that death occurred, on the date stated above, at 11 55 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Chr Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thibut & Blake M. D.

, 19 (Address) 1014 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fredericksburg, Virginia

DATE OF BURIAL: April 11-1922

20 UNDERTAKER: Bertram B Gore

ADDRESS: 1123 W Lexington St

D 63303

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63303

CERTIFICATE OF DEATH.

3 74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balto. General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Edward Overdick.

(Residence in Baltimore: No. 1529 Aliceanna St. St.; 52 yrs. 5 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. October 7th. 1869
(Month) (Day) (Year)

7-AGE. 52 yrs. 5 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Hardwood finisher. 186
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS

10-NAME OF FATHER. Charles Overdick.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Louise Sundry.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. H. Overdick Jr. (brother)

(Address) 1529 Aliceanna St.

15- Filed APR 10 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6th. 1922, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Acute Uraemia.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....
(Duration) .....yrs.....mos.....ds.

(Signed) Otto W. Rembard M. D.
(Coroner)

Apl. 8th. 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? S. T. Ganter's factory
Extend & Leadenhall sts.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
1st Evangelical Cem.	April 10 1922
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Fleet St.

is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified, so that

Spec.—6-9-12—H. P. Co.—1000 Bks.

D 63304

HEALTH DEPARTMENT—CITY OF BALTIMORE

63304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City Hosp. Bay View 100-481

CITY OF BALTIMORE: (No. ____ ST.: ____ WARD) Registered No. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Becker

(a) RESIDENCE. NO. ____ ST., ____ WARD. ____

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 85; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cab. maker

(b) General nature of industry, business, or establishment in which employed (or employer): 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Hosp. Records

15 APR 10 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-1922

17 I HEREBY CERTIFY, That I attended deceased from 3-30-1922, to 4-8-1922, that I last saw h[illegible] alive on 4-8-1922, and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) Clyde McNeil, M. D.

4-10 1922 (Address)

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenly Cem.

DATE OF BURIAL: 4/14/1922

20 UNDERTAKER: Jas Degnan & Son

ADDRESS: 1000 Pacific

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63305

D 63305

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH Church Home and Infirmary.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 76 N. Broadway ST., 6 WARD)

2-FULL NAME Mrs. Emma Brown.

(a) RESIDENCE NO. Church Home and Inf. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ½ mos. ½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~ widowed, or ~~divorced~~ ~~INSERT~~ (or) WIFE of Harry Brown

6 DATE OF BIRTH (month, day, and year) Oct 26-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	80	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER William Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Church Home Records

(Address) Broadway & Fairmount Ave

15 Filed APR 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from March 21, 19 22, to April 8, 19 22,

that I last saw her alive on April 8, 19 22,

and that death occurred, on the date stated above, at 2.26 P. m.

The CAUSE OF DEATH* was as follows:

Myocardiac Insufficiency

Auricular Fibrillation.

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Thrombosis Femoral Artery & Gangrene of leg (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard G. Coblentz, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Apl 10 1922

20 UNDERTAKER H E Hughes

ADDRESS 1 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63306

CERTIFICATE OF DEATH.

15-49

63306

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 Ridgewood Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie O'Connor

(a) RESIDENCE. No. 1934 Ridgewood Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Teale
(Address) 1934 Ridgewood Ave.

15 Filed APR 10 1922 F. E. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1921, to April 8, 1922, that I last saw her alive on April 8, 1922, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Bladder

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John D. Quinn, M. D.

4/9, 1922 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Maria Lowson. DATE OF BURIAL: 4/11 1922

20 UNDERTAKER: Martin Tuckey Sons ADDRESS: 1827 N. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63307

HEALTH DEPARTMENT—CITY OF BALTIMORE

63307

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital 153

CITY OF BALTIMORE: (No. Lombard & Greene ST. 28 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin M Vandeventer Van Deventer

(a) RESIDENCE. No. 4323 Walnut ave ST. Ragner Heights WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Anna M Vandeventer

6 DATE OF BIRTH (month, day, and year) September

7 AGE: Years 61 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work: Grocer. Retired 934

(b) General nature of industry, business, or establishment in which employed (or employer): Employer

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Cornelius Vandeventer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Cecelia Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs Anna M Vandeventer

(Address): 4323 Walnut Ave

15 Filed APR 10 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-4, 1922, to 4-8, 1922

that I last saw him alive on 4-8, 1922

and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was, as follows:

Cellulitis neck.

OVW

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-5-22

Was there an autopsy? yes

What test confirmed diagnosis? clinical findings

(Signed) Opie D. Hartline, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 4/10 1922

20 UNDERTAKER: Martin Luther & Sons

ADDRESS: 1837 N North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of cellulitis unknown.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63308

HEALTH DEPARTMENT—CITY OF BALTIMORE

21 D 63308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City Hosp. Bay View

CITY OF BALTIMORE: No. ..... St.: 9 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cassandra Butler

(a) RESIDENCE. No. 1521 Hartford Ave St., Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Columbus Butler

6 DATE OF BIRTH (month, day, and year) Dec 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo Ketring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hosp. Record (Address)

15 Filed ....., 19 ..... ROBERT R. KRAUTER, Registrar

APR 10 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 8 22

17 I HEREBY CERTIFY, That I attended deceased from 4-7-22 19..., to 4-8, 19 22

that I last saw h alive on 4-8, 19 22

and that death occurred, on the date stated above, at 9.15 P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

(Address) City Hosp. Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	4/11 22
20 UNDERTAKER William Cook	ADDRESS 602 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

63309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 63309

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.) 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Grobel (STROBEL)

(Residence in Baltimore: No. 63 - 625 - Catonsville Rd St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 5-4 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Geo. Grobel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER L. V. Eharon

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Grobel

(Address) 5318 Drumm

15-

Filed APR 10 1922 191.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 8 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart (Embolism)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Edema Edema

Pneumonia (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. T. Ruby M. D. (Coroner.)

Apr 9 1922 (Address) 1459 Bush

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, 4/10, 1922

20-UNDERTAKER William Cork — ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63310

CERTIFICATE OF DEATH.

179 D 63310

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. St. Josephs Hospital St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wilson

(Residence in Baltimore: No. Little Sisters of the Poor St.; W yrs. mos. ds.)

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) VS (Day), 1849 (Year)

7-AGE, 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer). D.31

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm [illegible] Wilson

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Mary [illegible] Slater

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eunice Swansberry

(Address) 1714 West Balto

15-

Filed APR 10 1922 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 6 1922 to April 8 1922 that I saw him alive on April 8 1922, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows: F.D.C.

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. ds.

(Signed) S. W. Kenney M. D.

, 191... (Address) St. Josephs Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 11 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1714 W Balto St

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, 4.12., 1922

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

Skrivanek

D 63311 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63311

CERTIFICATE OF DEATH.

K118-002

1-PLACE OF DEATH Bayview. REGISTERED NO.

CITY OF BALTIMORE: (No. 25 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aylin Skrivanek

(a) RESIDENCE NO. Elkridge Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Skrivanek

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria Hungary

PARENTS

10 NAME OF FATHER Joseph Skrivanek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Julia Skrivanek (Address) Elkridge Md

15 APR 10 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to Apr. 9, 1922, that I last saw h.. alive on Apr. 9, 1922, and that death occurred, on the date stated above, at 9 50P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 7-22

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. Scott M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Augustine Elkridge DATE OF BURIAL Apr 12 1922

20 UNDERTAKER Jobbe F Cowgill & Son ADDRESS Per F. J. Cowgill 901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63312

D 63312

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 23 W. West St. 23 WARD)

2-FULL NAME Bridget A. Manning

(a) RESIDENCE. No. 23 W. West St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Michael F. Manning

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 63 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Jeremiah Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Michael F. Manning (23 W. West St.)

15 Filed ..., 19 ... Registrar

APR 1 01922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to Apr 9, 1922

that I last saw h[illegible] alive on Apr 7, 1922

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Steiger M. D.

4/9, 1922 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Apr. 11 1922

20 UNDERTAKER: Margaret F. Flynn

ADDRESS: 1422 Light St.

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63313

HEALTH DEPARTMENT—CITY OF BALTIMORE

160

D 63313

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4623 Pimlico Rd. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Geoge McDonald.

(a) RESIDENCE No. 4623 Pimlico Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 19-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Allen McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada.

12 MAIDEN NAME OF MOTHER Euphemia McIsaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass.

14 Informant Frank Allen McDonald
(Address) 4623 Pimlico Rd.

15 APR 1 01922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9 1922

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 8, 1922, that I last saw him alive on April 8, 1922, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

"Congenital debility"

"Icterus Neonatorum"

(duration) yrs. 3 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. Hallie Hemming, M. D.

4/9, 1922 (Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL April 10 1922

UNDERTAKER Margaret G. Flynn

ADDRESS 14 N Eutaw St

John D Browning

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63314

100-001

D 63314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay view Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 12 WARD)

2-FULL NAME John Browning

(a) RESIDENCE. No. 810- E. Po 4th. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Browning

6 DATE OF BIRTH (month, day, and year): Unknown

Years	Months	Days	If LESS than 1 day, hrs. or min.
75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer): 011

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Ed. Browning

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Nancy Carmichael

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Hosp Records Bay View Hospital

15 FILED: APR 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/6/22 19..., to 4/9/22 19..., that I last saw h... alive on 4/9/22 19..., and that death occurred, on the date stated above, at 1 PM

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

4/9, 1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: 4/11/22

20 UNDERTAKER: William Cook

ADDRESS: 502 E North

CAUSE OF DEATH—Please fill in the plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63315

D 63315

CERTIFICATE OF DEATH.

25 - 179

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dillingham

(a) RESIDENCE. No. 3rd Ave. Fairfield ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 870

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital

15 Filed APR 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1922

17 I HEREBY CERTIFY, That I attended deceased from February 4, 1922 to April 5, 1922

that I last saw her alive on April 4, 1922

and that death occurred, on the date stated above, at 1:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fairfield.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

4/5/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL Apr 1922

20 UNDERTAKER Commissioner of Health

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63316

CERTIFICATE OF DEATH.

001

100 D 63316

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bennett

(a) RESIDENCE. NO. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed APR 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3 . 1922. to April 4 . 1922, that I last saw him alive on April 3 . 1922. and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

4/4/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL 19

20 UNDERTAKER Undertaker ADDRESS 1922

Deputy Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63317

CERTIFICATE OF DEATH.

100-001 D 63317

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 7 WARD)

2-FULL NAME John Mullin

(a) RESIDENCE. No. 1920 Alice Ann St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	--	--	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Owen Mullin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Gartler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, Municipal Hospital

15 Filed APR 10 1922 ROBERT T. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1922, to April 5, 1922, that I last saw him alive on April 5, 1922, and that death occurred, on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

4/6/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health ADDRESS 1922

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63318

179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Simpson

(a) RESIDENCE. NO. 1014 Whitemore Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1878 - Jan. 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed APR 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 7, 1922, that I last saw her alive on April 7, 1922, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH was as follows:

Hypertension; Chronic Nephritis (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? W. P. N. 8+ mgm B.P. 220

(Signed) Clyde McNeil, M. D.

4/8/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL: April 10 1922

20 UNDERTAKER: F. B. Skippert ADDRESS: 2258 Frederick Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63319

CERTIFICATE OF DEATH.

23 D 63319

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (St. Agnes Hospital ST., 20 WARD)

2-FULL NAME Hilda Michael

(a) RESIDENCE NO. 2544 N. Lombard St. (St. 20 ct WARD .....)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 25-1906

7 AGE 16 Years Months 2 Days 16 If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Peter H. Michael

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Mabel Money

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Mrs. W. Michael

(Address) 2544 N. Lombard St

15 APR 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-30, 1922, to 4-8, 1922.

that I last saw h[illegible] alive on 4-8, 1922

and that death occurred, on the date stated above, at 12 25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(duration) .....yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

.....(duration) .....yrs. .....mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL April 11 19

20 UNDERTAKER F B Wappet — ADDRESS 2736 Frederick

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating in the water 24 18 V Registered No. C.....

City of BALTIMORE: (No. Foot of Cross St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Huffnagel. 35 ----------.

(Residence in Baltimore: No. 548 E. Fort Ave. St.; yrs...mos...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. July 2, 1873. 1.....
(Month) (Day) (Year)

7-AGE. 48 yrs. 5 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 674

9-BIRTHPLACE. (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Ludwig Huffnagel.

11-BIRTHPLACE OF FATHER. (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Maria ----------.

13-BIRTHPLACE OF MOTHER. (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minna Huffnagel. (wife).

(Address) 548 E. Fort Ave.

15. Filed APR 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Missing December 9, 1921. Found April 8, 1922. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs...mos...ds.

(Signed) Otto W. Reinhardt M. D.
(Coroner.)

Apr. 10, 1922. (Address) 1917 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	April 10 1922
20-UNDERTAKER. Robt. H. Turner Inc	ADDRESS 1442 N. Broadway.

Is very important. See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Bks.

D 63321 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63321

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS H'SPIT'L ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Bauer

(a) RESIDENCE NO. 11 Elizabeth Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24 1916

7 AGE: Years 6 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Paul Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Y

12 MAIDEN NAME OF MOTHER Bertha Penning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) JOHNS HOPKINS H SPITAL.

15 Filed APR 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 8th, 1922, to April 9th, 1922, that I last saw him alive on April 9th, 1922, and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine & Blood sugar -

(Signed) Horace G. Stewart, M. D.

4/9, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Catholic Cemetery

DATE OF BURIAL: Apl 12 1922

20 UNDERTAKER: Clark & Turner Bros

ADDRESS: 414 Druid Hill Ave

No 1377

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63322 ✓003 181 D 63322

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 Barclay ST., 12 WARD)

2-FULL NAME Dorothy. May. Tarbert.

(a) RESIDENCE NO. 2414 Barclay ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) November 2nd 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Frank L. Tarbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Emma J. Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mr. Frank L. Tarbert
(Address): 2414 Barclay St

15 APR 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1922, to April 8, 1922, that I last saw her alive on April 8, 1922, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Ether Narcosis + Cardiac Paralysis
following Emasculation
O.K. Corner J. J. Mooney

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of April 8-22

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. P. Carman M. D.

April 8, 1922 (Address) 1701 N. Carolin ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Apr. 11 1922

20 UNDERTAKER: Henry Hosch Son — ADDRESS: 1301 E Eager, b

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63323 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63323

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Loudon Park Cem. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saml M. Mitchell

(a) RESIDENCE. NO. Loudon Park Cem. ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delia Mitchell

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stable Boss

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Howard Co, Md

PARENTS

10 NAME OF FATHER Thomas Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Delia Mitchell (Address) Loudon Park

15 [illegible] Robert F. Harrison, Registrar

R 1 0 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch 15, 1922, to Apl 9, 1922, that I last saw him alive on April 8, 1922, and that death occurred, on the date stated above, at 9.35 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) P. H. Dill, M. D.

4/10 1922 (Address) 430 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	April 12 1922
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3409 Fredk Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 63324

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 601 N. Monroe ST., 16 WARD)

2-FULL NAME Thomas E. Kelly

(a) RESIDENCE NO. 601 N Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget Ann

6 DATE OF BIRTH (month, day, and year) Jan 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stat. Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer) 030

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jno. Tully

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm. Jerome Kelly

(Address) 601 N. Monroe St

15 Filed APR 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1922

17 I HEREBY CERTIFY, That I attended deceased from 1/13, 1922, to 4/8/22, 19..., that I last saw h— alive on 4/7/22, 19..., and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Epithelial Larynx

(duration) Hist yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Tenny, M. D.

4/9/1922 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 4-11-1922

20 UNDERTAKER H C Brauning & Son

ADDRESS 617 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63325

CERTIFICATE OF DEATH.

49 D 63325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Patapsco ST.: 23 WARD)

2-FULL NAME Sallie E Tompkins

(a) RESIDENCE. NO. 1609 Patapsco ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene E Tompkins

6 DATE OF BIRTH (month, day, and year) Feb 4 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER George Williamson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

11 Informant Mrs Eugene Tompkins (Address) 1609 Patapsco

15 Filed Apr 12 1922 H. P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9-22

17 I HEREBY CERTIFY, That I attended deceased from 3-9-22 19 to 4-9-22 19, that I last saw her alive on 4-9-22 19, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lympho-Sarcoma

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Lee Butler, M. D.

4/10, 1922 (Address) 1819 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Campbell Co. Va	April 12 1922
20 UNDERTAKER Lynch & Co.	ADDRESS
Mrs J. E. Saunders	1218 E. Lombard

Burial Permit Issued

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gland of Neck

Spec.—1-10-21—M&T—1500 Bks.

D 63326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63326

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 N. Charles ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet A. Blake

(a) RESIDENCE NO. 1212 N Charles ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of George A. Blake

6 DATE OF BIRTH (month, day, and year) Jan 17 1840

7 AGE — Years: 82 — Months: 2 — Days: 22 — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

937

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William O Griggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Curtain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George A Blake (Husband)

(Address) 1212 N Charles St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from 1919 to April 8 1922

that I last saw her alive on April 8 1922

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis (diffuse)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

2 days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) Hartley, M. D.

19 (Address) 1629 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4-11 1922

20 UNDERTAKER: E and B Hasle

ADDRESS: 115 E West St

1 0 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital 91 Registered No. C.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Mulhall

(Residence in Baltimore: No. 717 E Pratt St. St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. ..... 1.....
(Month) (Day) (Year)

7-AGE. 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 40

9-BIRTHPLACE, (State or Country) Ireland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bruce

(Address) .....

15- Filed APR 21 1922, 192.....
Robert J. Griffith
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31 1922
..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

..... 192.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross R.C. (Mt Cemetery) DATE OF BURIAL, April 13-1922

20-UNDERTAKER, [illegible] ADDRESS

Is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND
Bureau of Vital Statistics

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63328

CERTIFICATE OF DEATH.

D 63328

REGISTERED NO. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 N. Franklin ST., 19 WARD)

2-FULL NAME Infant of Margaret & Thomas Foreman

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Foreman

11 BIRTHPLACE OF FATHER (city or town) Dansville
(State or country) Texas

12 MAIDEN NAME OF MOTHER Margaret Nelson

13 BIRTHPLACE OF MOTHER (city or town) Fairmount
(State or country) W. Virginia

14 Informant Thomas Foreman
(Address) 1613 N. Franklin.

15 [illegible] 1922 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1922

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 .....

that I last saw h..... alive on ..... 19 .....

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Underdeloped.
Was - Clause of foramen Ovale.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John Houff, M. D.

19 (Address) Health Office 19th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] HOPKINS HOSPITAL

DATE OF BURIAL APR 8 1922

20 UNDERTAKER Robert P. Martin

ADDRESS [illegible] Baltimore Md.

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63329 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 74

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Carney

(a) RESIDENCE. NO. Unknown ST.: 2939 Huntingdon Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Pat McDonnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Megoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed [illegible], 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17 I HEREBY CERTIFY, That I attended deceased from December 20. 1920. to April 10. 1922. that I last saw her alive on April 9. 1922. and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria adiposa genitalis 20 yrs

Cerebral hemorrhage 6 mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

4/10/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 4/12 1922

20 UNDERTAKER William Cook

ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63330

CERTIFICATE OF DEATH.

31

D 63330

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Hobbs

(a) RESIDENCE. No. 640 W. Fayette st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Cornelius Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Muscgrave

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address) Hospital Records M.T.H.

15 1922 . 19 Robert P. Hartman Registrar

Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from February 11, 1922, to April 10, 1922, that I last saw him alive on April 10, 1922, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Padagliacco M. D.

4-10-22. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harmony Hound Co.

DATE OF BURIAL: 4/12 19

20 UNDERTAKER: Wiseman Cook

ADDRESS: 502 E Nash

1

PLEASE WRITE PLAINLY in permanent ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63331 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Damon E. Caswell

(a) RESIDENCE NO. 1301 Farragut ST., ~~WARD~~ Washington D.C.

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Caswell

6 DATE OF BIRTH (month, day, and year) Sept 26th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Abram Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Caroline Burch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Record.

15 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 31st, 1922 to April 7th, 1922 that I last saw him alive on April 7th, 1922 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia terminal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood examinations

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 11 1922

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 B Way

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63332

162

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Aisquith St., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Lefenson

(a) RESIDENCE NO. 505 Aisquith St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years — Months — Days — If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city Md

PARENTS

10 NAME OF FATHER Oscar Lefenson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Carolshell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Balto st

15 Filed .19 Registrar

Robert F. Carrison,

Burial in Mt Olivet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 19

17 I HEREBY CERTIFY, That I attended deceased from April 9. 1922. to April 9. 1922.

that I last saw h[illegible] alive on April 9. 1922

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Born premature

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Baughn M. D.

9/10 .1922 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern circle Cem DATE OF BURIAL 9/10 1922

20 UNDERTAKER: Jack Lewis 1439 E Balto ADDRESS

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63333

CERTIFICATE OF DEATH.

D 63333

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST.: ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Americus Scarborough

(a) RESIDENCE. NO. Wachapreague, Va ST., ... WARD. Wachapreague Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. H. A. Scarborough

6 DATE OF BIRTH (month, day, and year) Nov. 11 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Mitchell Scarborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Hannah Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. H. A. Scarborough
(Address) Wachapreague Va

15 Filed ..... 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1922, to Apr. 10, 1922, that I last saw h.. alive on Apr. 10, 1922, and that death occurred, on the date stated above, at 12 50 P.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

(duration) 5 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage + Shock following operation (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? Yes Date of Apr. 10, 22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Paul W. Sutton, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Wachapreague Va 4-11 1922

20 UNDERTAKER Turner & Jenkins Bros Co — ADDRESS McCullough & Orchard

Wachapreague Va

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63334 HEALTH DEPARTMENT—CITY OF BALTIMORE

84 D 63334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS H SPITAL ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. W. Hendley, Jr.

(a) RESIDENCE NO. 4409 Greenway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	11			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. W. Hendley

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D C

12 MAIDEN NAME OF MOTHER Genevieve Holtzman

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D C

14 Informant JOHNS HOPKINS HOSPITAL (Address) Road.

15 Filed ... 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1922, to April 10, 1922, that I last saw him alive on April 9, 1922, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Lesions of Brain

Cerebellum

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Post operative shock

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of April 9, 22

Was there an autopsy? No.

What test confirmed diagnosis? Operative findings.

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 4-11 1922

20 UNDERTAKER Herzog & Jenkins Assts

ADDRESS Pratt & Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

D 63335

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 63335

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 125 E. Cross ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Premature Birth
Infant of Chas & Nellie Hoglund

(Residence in Baltimore: No. 125 E Cross St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6-DATE OF BIRTH: April 9 (Month) (Night) (Day), 1922 (Year)

7-AGE: 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 14 hrs., 45 min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Premature birth
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Chas. Frederick Hoglund

11-BIRTHPLACE OF FATHER (State or country): Sweden

12-MAIDEN NAME OF MOTHER: Nellie Macek

13-BIRTHPLACE OF MOTHER (State or country): Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert W Kowalski

(Address) 125 E Cross St

15-

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1922, to, April 10 1922, that I saw h[illegible] alive on April 10 1922, and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:

- Premature birth -

14 hours and 45 minutes (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Samuel Silverstein M. D.

April 10 1922 [Address] 22 S Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: 4-10 1922

20-UNDERTAKER: E T B Hurle

ADDRESS: 115 E North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert P Harrison
Burial Permit Clerk

D 63336

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 63336

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 639 Jasper ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Price

(Residence in Baltimore: No. 639 Jasper St.; 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, December, 1886
(Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer (Tobacco)
(b) General nature of industry, business, or establishment in which employed (or employer) (Tobacco Factory)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Price

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Josephine Brighton

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Fremont Ave.

15-

1922, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Newman M. D.
(Coroner.)

April 10, 1922 (Address) 230 E. Monument Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, [redacted] DATE OF BURIAL, April 11, 1922

20-UNDERTAKER Daniel Easton ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63337

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH City Hosp. Bayview

CITY OF BALTIMORE: (No. ..... ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Carter

(a) RESIDENCE. NO. 322 W. Preston ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1844

7 AGE — Years: 78 — Months: ..... — Days: ..... — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook yrs

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Hosp Records

15 Filed APR 6 1922, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 8 19 22

I HEREBY CERTIFY, That I attended deceased from 4-6 — 19 22 to 4-8 — 19 22

that I last saw her alive on 4-8 — 19 22

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic nephritis

(duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Clyde McNeill, M. D.

4-8 19 22 (Address) City Hosp. Bayview

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pr. Auburn Cem — DATE OF BURIAL: Apr. 12 19 22

20 UNDERTAKER: Daniel Easton — ADDRESS: Pt Edmonds

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63338

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 E Fairmount St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank X Ritter

(a) RESIDENCE. No. 1523 E Fairmount St. 6 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Regina Ritter

6 DATE OF BIRTH (month, day, and year) October 7 18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lucy H Hyman

(Address) 1922 Hanover

15 Filed APR 1 1922, 19

Registrar

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17

I HEREBY CERTIFY, That I attended deceased from March 9, 1922, to April 9, 1922,

that I last saw him alive on April 9, 1922,

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Y

What test confirmed diagnosis? Clinical

(Signed) Chas A Schaefer, M. D.

, 19 (Address) 53 S. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 19 22
20 UNDERTAKER	ADDRESS
Randall & Medstow	3, 8 Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63339

CERTIFICATE OF DEATH.

164

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Carrollton Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Keller

(a) RESIDENCE. No. 822 N. Carrollton ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 18 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harpers Ferry
(State or country) Va

PARENTS

10 NAME OF FATHER Charles Keller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mary C. Robb Supt
(Address) 822 N. Carrollton ave.

15 Filed Robert P. Harrison 19 Registrar

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9- 1922

17

I HEREBY CERTIFY, That I attended deceased from March 31- 1922, to April 9- 1922, that I last saw him alive on April 9- 1922, and that death occurred, on the date stated above, at 7 9- m.

The CAUSE OF DEATH was as follows:

acute Dilitation of heart, & heart failure probably due to acute Endocarditis.

(duration) 10 days yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema, anemia & senility Tentpunct

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carlton M. Cook, M. D.

, 19 (Address) 1107 W Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 11 1922
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63340

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1236 Dellwood Ave. Hampden 181-001 REGISTERED No. C.....

CITY OF BALTIMORE (No. 1236 ST. Dellwood Ave. WARD 9)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Doyle

(Residence in Baltimore: No. 2021 Robb St. St.: yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-~~SINGLE,~~ MARRIED, ~~WIDOWED,~~ OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 12 (Day), 1861 (Year)

7-AGE, 60 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Doyle

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James McCarthy

(Address) 2021 Robb St

15- Robert P. Harrison, ..., 191.....

10922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) ....find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound Accidental

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) John Thomson M. D.
(Coroner)
April 10 1922 (Address) 732 Robb

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, April 11, 1922

20-UNDERTAKER Geo J. Ruth — ADDRESS 1735 Hanford ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Illuminating gas.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis.*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 63341

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 63341

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 N Bruce ST., 16 WARD)

2-FULL NAME Joseph Brafton

(a) RESIDENCE NO. 620 N Bruce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Boy

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Baltimore
(State or country) ..... Md.

PARENTS

10 NAME OF FATHER Edgar Brafton

11 BIRTHPLACE OF FATHER (city or town) ..... Balto
(State or country) ..... Md.

12 MAIDEN NAME OF MOTHER Ella Scott

13 BIRTHPLACE OF MOTHER (city or town) ..... Balto
(State or country) ..... Md.

14 Informant .....
(Address) .....

15 Robert F. Harrison, Burial Permit Clerk. Registrar

APR 10 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 19 22

17 I HEREBY CERTIFY, That I attended deceased from April ....., 19 22, to April 8 ....., 19 22,
that I last saw h... alive on Apr 8 ....., 19 22
and that death occurred, on the date stated above, at 2. 40 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza Lobar Consolidation

..... (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? yes Town,

Did an operation precede death? Yes Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Schmidt, M. D.

April 11, 19 22 (Address) 1707 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL April 11-22

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 74

CITY OF BALTIMORE: (No. Preston & Valley — St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Thomas C. Carmack.

(a) RESIDENCE. No. Little Sisters of the Poor. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Middleburg, (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Hanson Carmack

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER Harriet Clay Blalock born

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Sister Florence, (Address) Preston & Valley Sts.

15 Filed Oct. 19[illegible] [illegible], Registrar

R 10822 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Prior to record 19 to 19, that I last saw h live on April 9 1922, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Apr. 11 1922
20 UNDERTAKER	ADDRESS
W. C. Wadefield	9 E Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63343

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63343

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Ashland Ave. WARD) 10

2-FULL NAME Josephine Roberts

(a) RESIDENCE NO. 1421 Ashland Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Roberts

6 DATE OF BIRTH (month, day, and year) Dec 25 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph McKelvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James E Roberts

(Address) 1421 Ashland ave

15 Filed 4/10 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 9, 1922, that I last saw h— alive on April 9, 1922, and that death occurred, on the date stated above, at 11:00 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ? yrs. ? mos 5 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ? yrs. ? mos. 5 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S Fenby M. D.

4/10, 1922 (Address) 8522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Apr 13 1922

20 UNDERTAKER Wm J Hickey & Son ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 63344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63344

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2844 W. North Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clyde Raymond Durrett

(a) RESIDENCE. No. 2844 W. North Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. X mos. X ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edith E. Durrett (wife)

6 DATE OF BIRTH (month, day, and year): May 17 -

7 AGE

Years	Months	Days	If LESS than 1 day hrs. or min.
36	11	21	X /

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Auto driving 073

(b) General nature of industry, business, or establishment in which employed (or employer): Outside Dept.

(c) Name of employer: Grief & Co

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Thos. Durrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Lula E. Mann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond - Va.

14 Informant (Address): Mrs. Edith E. Durrett 2844 W. North Ave.

Robert F. Harrison,

Burial Permit Clerk.

R 10922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4.9 1922

17 I HEREBY CERTIFY, That I attended deceased from 2-15, 1922, to 4.9, 1922, that I last saw him alive on 4.8, 1922, and that death occurred, on the date stated above, at 10 a, m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 2 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Exhaustion from Phthisis Pulmonalis (duration) X yrs. 2 mos. X ds.

18 Where was disease contracted if not at place of death? In Grief & Co's employ.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? City Health Dept.

(Signed) P. Bethlehem, M. D.

, 19 (Address) 1124 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 11 1922
20 UNDERTAKER	ADDRESS
Harry F. Witzke	1531 Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63345

99-007

D 63345

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2939 Westwood ST., 15 WARD)

2-FULL NAME John Clifton Kurlett

(a) RESIDENCE NO. 2939 Westwood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kurlett

6 DATE OF BIRTH (month, day, and year) Jan 14 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER John W Kurlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Catherine Sandretto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Catherine Kurlett

(Address) 2939 Westwood Ave

15 [illegible] 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-3-, 1919, to 4-9-, 1922, that I last saw him alive on 4-8, 1922 and that death occurred, on the date stated above, at 6,30 P m.

The CAUSE OF DEATH* was as follows:

Chron. Bronchitis

" Bronchiectasis

" asthma.

about (duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas Conner, M. D.

4/10 1922 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 12 1922

20 UNDERTAKER H. W. Cook — ADDRESS A+G Mc.

R1 [illegible]22

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 63346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63346

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2921 Winchester ST., 16 WARD)

2-FULL NAME Thos. H. H. Stansfield

(a) RESIDENCE No. 2921 Winchester ST., 16th WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Stansfield

6 DATE OF BIRTH (month, day, and year) Nov 15, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER T. B Stansfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annie E. Stansfield

(Address) 2921 Winchester Ave

Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1922.

17 I HEREBY CERTIFY, That I attended deceased from Mar 29, 1922 to Apr 9, 1922

that I last saw him alive on Apr 9, 1922

and that death occurred, on the date stated above, at 10-10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. Exam.

(Signed) John H. Whitehead M. D.

Apr 9 1922 (Address) 1219 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Vernon Cemetery Co	4/12 1922

20 UNDERTAKER Wm Cook ADDRESS 502 E North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Raised 12 19 Coupla, Grove

D 63347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Charles & North ave ST. 12 WARD)

2-FULL NAME Frank. Stone

(Residence in Baltimore: No. 31 - E - 21st St St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) M

6-DATE OF BIRTH ..... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050

9-BIRTHPLACE (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Schands

(Address) 502 E Chas st

15- Robert P. Harrison,

Filed ....., 191.....
Registrar.

Burial Permit Clerk.

01922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 3, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture Skull due to a fall Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

April 5, 1922 (Address) 1622 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemt

DATE OF BURIAL, April 11, 1922

20-UNDERTAKER William Lock

ADDRESS 502 E North Ave

Daes.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63348

CERTIFICATE OF DEATH. — 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 May ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elnora Dafes

(a) RESIDENCE. No. 1407 May ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of ~~WIFE of~~: John Dafes

6 DATE OF BIRTH (month, day, and year): Jan 17-1879

7 AGE — Years: 43 — Months: 2 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): — 137

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Chestertown Md

PARENTS

10 NAME OF FATHER: William Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): John Dafes 1409 May St

15 Filed APR 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to April 8, 1922, that I last saw h[illegible] alive on April 8, 1922, and that death occurred, on the date stated above, at 8.40 A. m.

The CAUSE OF DEATH* was as follows:

Abscess Intestines Syphilis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Robt J Grimm, M. D.

4-10, 1922 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Apr. 12 1922

20 UNDERTAKER: Chas. H. Edmondson — ADDRESS 476 N. Caro

THION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 63349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 X 6

D 63349

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Quarantine Station (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hugh McDonald.

(a) RESIDENCE NO. Havre de Grace ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Race Horse Owner.

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Hungary Canada

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Wife, and Brother
(Address)

15 APR 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1922, to April 7th, 1922,
that I last saw him alive on April 7th, 1922
and that death occurred, on the date stated above, at 11.15 p.m.

The CAUSE OF DEATH* was as follows:

Smallpox (confluent-)
Sepsis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Delirio absorbtion-
Thrombosis-Arteries
(duration) yrs. mos. ds.

18 Where was disease contracted? Mobile. Ala.
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. R. Richardson M. D.

, 19 (Address) U.S. Quarantine Sta.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Quarantine Reservation.	Apr. 8th 1922

20 UNDERTAKER none allowed ADDRESS

By Quarantine attendants.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63350 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63350

CERTIFICATE OF DEATH. 164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Madison Av. WARD 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A. Leavitt

(a) RESIDENCE. No. 2804 Webster Av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Henry C. Leavitt

6 DATE OF BIRTH (month, day, and year) May 3/1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co. Md.

PARENTS

10 NAME OF FATHER Wm C. Leavitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Kennard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Alvin Leavitt
(Address) 2804 Webster Av

15 Filed APR 1 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1922, to Apr. 10, 1922, that I last saw her alive on Apr. 9, 1922, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Gradual decline of old age, no disease

(duration 3 dys. yrs. mos. ds.)

CONTRIBUTORY (Secondary) Too weak to take nourishment

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edw Smith M. D.

4/10 1922 (Address) 1605 N. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Apl 12th 1922
20 UNDERTAKER Entwisle & Gore	ADDRESS 1223 W. Lafayette Ave

CAUSE OF DEATH must be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63351 HEALTH DEPARTMENT—CITY OF BALTIMORE 179 D 63351

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Walker ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Richards

(a) RESIDENCE NO. 1607 Walker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Sept 14 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	-			

8 OCCUPATION OF DECEASED

(a) Trade, profesion or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Marlon Richard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Jamie Richard
(Address) 1607 Walker St

15 APR 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1922 to April 9, 1922

that I last saw her alive on April 8 - , 1922

and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

apoplexy
Bright Disease + asthma
+ Dropsy

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Bright Disease asthma + Dropsy (duration) 1 yrs. 8 mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. J. W. Kennard, M. D.

4-10 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt - Auburn Cem — DATE OF BURIAL April 12, 1922

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

154412
D 63352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63352

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS H.SPITAL ST., 10 WARD)

2-FULL NAME Charles King. Belte, Md.

(a) RESIDENCE NO. 616 N. Central Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown. yrs. mos. ds. How long in U. S., If ~~of foreign birth~~? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Piercy King (wife)

6 DATE OF BIRTH (month, day, and year) Aug 27, 1867

7 AGE: Years 54 | Months 7 | Days 12 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Jot Work
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Brunswick Co Va

PARENTS

10 NAME OF FATHER: King King.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brunswick Co Va.

12 MAIDEN NAME OF MOTHER: Anne Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brunswick Co Va

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Baltimore.

15 Filed APR 11 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1922. to April 9, 1922.
that I last saw him alive on April 9, 1922,
and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration, myocardial insufficiency, arteriasclerosis.

Several years (duration) 6 yrs.? mos ds.

CONTRIBUTORY (Secondary) Lobar pneumonia (duration) yrs. mos. 4-5 ds.

18 Where was disease contracted if not at place of death? Unknown.
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy.
(Signed) E. Cowles Andrus, M. D.
, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shelmer N C

DATE OF BURIAL: April 12, 1922

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

Sped 6-9 1000 Bks.

D 63353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

135 D 63353

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.: S WARD)

2-FULL NAME William Middleton

(a) RESIDENCE. NO. Parkesley Virginia WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~wife of~~ Mrs Fanna Middleton

6 DATE OF BIRTH (month, day, and year) June 12 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69 years	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Julia Groves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Fanna Middleton
(Address) Parkesley Va

15 Filed APR 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-4 1922 to 4-11 1922

that I last saw him alive on 4-11 1922

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Benign hypertrophy of Prostate (duration) Not Known ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-6-22

Was there an autopsy? no What test confirmed diagnosis? Clinical finding.

(Signed) W S Jones, M. D.

4/11 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Md	April 11 1922

20 UNDERTAKER William Cook ADDRESS 502 E. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63354 — 179 — D 63354

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 N. Broadway ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Booth

(a) RESIDENCE No. 1428 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hendrika Booth

6 DATE OF BIRTH (month, day, and year): Aug 16 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

(c) Name of employer: P. R. R.

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: James Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Rachel Brobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Hendrika Booth
(Address): 1428 N. Broadway

15 Filed APR 11 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 9, 1922, that I last saw him alive on April 9, 1922, and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) D. Anna Fuller, M. D.

(Address) 1506 N. Broadway, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 12 1922

20 UNDERTAKER: H. Sander & Sons — ADDRESS: 710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Robinson 212 E. Preston St.

Spec.—1-10-21—M&T—1500 Bks.

D 63355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

M-D 63355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 E. Dallas ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Perihelio Fernandez

(a) RESIDENCE NO. 529 E. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1920

7 AGE — Years: 1 — Months: 7 — Days: 8 — If LESS than 1 day, ... brs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Antonio Fernandez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Batton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Antonio Fernandez

(Address) 529 E. Dallas St

15 Filed APR 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1922, to April 10, 1922,

that I last saw him alive on April 8, 1922,

and that death occurred, on the date stated above, at 2 00 A. m.

The CAUSE OF DEATH* was as follows:

DRN

Pulmonary Congestion

(duration) 7 yrs. 7 mos 10 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Robinson, M. D.

, 19 (Address) 212 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelicab Cemtery — DATE OF BURIAL: April 12 1922

20 UNDERTAKER: H. Gander & Sons — ADDRESS: 710 Flat St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Started with bronchopneumonia.
Meningitis simple.
No infectious disease

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63356

CERTIFICATE OF DEATH.

11-00 V

D 63356

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1128 Hull ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta Tudor

(a) RESIDENCE NO. 1128 Hull St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Edgar A Tudor

11 BIRTHPLACE OF FATHER (city or town) Dresden (State or country) Ohio

12 MAIDEN NAME OF MOTHER Fannie Newman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Fannie Tudor

(Address) 1128 Hull St

15 Filed APR 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 10, 1922,

that I last saw h[illegible] alive on April 9, 1922,

and that death occurred, on the ~~date stated above~~ April 10, at 10:45 m.

The CAUSE OF DEATH* was as follows:

Inanition 000

(Influenza followed by persistent vomiting)

(duration) — yrs. 1½ mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jas B Holmes M. D.

, 19 (Address) Cambridge Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL April 12 1922

20 UNDERTAKER J Herrig & Co

ADDRESS 2008 Adams

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of influenza & cold followed by vomiting. Unwise medication plus grippal condition probably cause of vomiting and nausea.

Spec.—1-10-21—M&T—1500 Bks.

153024 D 63357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001 D 63357

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS H SPITAL ST. 710 WARD)

2-FULL NAME Florence Bremer

(a) RESIDENCE No. 3703 Center Place ST. Highlandtown, WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ 7 mos. 26 ds. How long in U. S., if of foreign birth? ~~yrs.~~ mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or) WIFE of~~: Vela Bremer (mother)

6 DATE OF BIRTH (month, day, and year): Aug 14, 1921.

7 AGE — Years: — Months: 7 Days: 26 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: David Bremer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Vela Jefferies

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio.

14 Informant (Address): JOHNS HOPKINS H SPITAL Record

15 Filed APR 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922 to April 9, 1922, that I last saw her alive on April 9, 1922 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary): Influenza Meningitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? ?

What test confirmed diagnosis? Lumbar puncture

(Signed) Horace G. Stewart, M. D.

4/9, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: 4/11 1922

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baggs

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63358 173 D 63358

CERTIFICATE OF DEATH.

D 63358

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No.) ST. 16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora M. Baggs

(a) RESIDENCE. NO. 1932 Harlem Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Walter J Baggs

6 DATE OF BIRTH (month, day, and year): June 9, 1863.

7 AGE: Years 58 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westminster Md

PARENTS

10 NAME OF FATHER: Noah Lemark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Louise Shrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Cora M Baggs 1932 Harlem Ave

15 Filed APRIL 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/9/22 19

17 I HEREBY CERTIFY, That I attended deceased from 4/7/22, 19, to 4/9, 19 22, that I last saw her alive on 4/9, 19 22, and that death occurred, on the date stated above, at 4 25 p m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis - Chol. Cystitis

Abdominal Adhesions -

Acute obstruction of

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute obstruction Uremia Cardiac decompensation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1932 Harlem Ave

Did an operation precede death? yes Date of 4/5/22

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Wm Douglass, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Apr 12 1922

20 UNDERTAKER: George J Smith — ADDRESS 1000 N. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63359

CERTIFICATE OF DEATH.

D 63359

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3645 Cottage Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chia Feigman

(Residence in Baltimore: No. 3645 Cottage Ave St.; yrs., 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1840 (Year)

7-AGE, 82 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Hyman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fichel Borrow

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto St

15- Filed APR 11 1922 ROBERT N. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Heart
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
April 10, 1922. (Address) 3722 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rodeph Shalom	April 11, 1922
20-UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63360 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63360

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 638 Sterling St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Reese

(Residence in Baltimore: No. 638 Sterling St.

St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March, 1857
(Month) (Day) (Year)

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Rawlings

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Gross

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Spencer

(Address) 638 Sterling St

15-

Filed APR 11 1912 191.... GG Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 7, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Knox Guiteau M. D.
(Coroner.)

4-9, 1912 (Address) 814 E. Lex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, April 12, 1912

20-UNDERTAKER John H. Toadvine

ADDRESS 142 W. Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1430 D 63361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claudia Steckinger

(a) RESIDENCE NO. Oakdale Ave. ST. ..... WARD Raspburg, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David L. Steckinger

6 DATE OF BIRTH (month, day, and year) Dec. 19-1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Georgia

PARENTS

10 NAME OF FATHER Lamuel E. Steckinger

11 BIRTHPLACE OF FATHER (city or town) Ruben (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary M. Steckinger

13 BIRTHPLACE OF MOTHER (city or town) Ruben (State or country) Georgia

14 Informant JOHNS HOPKINS H. Staff (Address) Georgia

15 Filed APR 1 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4th, 1922, to April 11th 1922, that I last saw h e alive on April 11th, 1922, and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Uterine hemorrhage DVN
(Cause unknown)

..... (duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of April 3, 22

Was there an autopsy? NO

What test confirmed diagnosis? .....

(Signed) Jo Bass, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Springfield Georgia — DATE OF BURIAL April 11 1922

20 UNDERTAKER Joseph Abrens — ADDRESS 22 N Bro

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Miscarriage 2 or 3 mos ago. Operation for lacerated cervix. Relaxed vaginal outlet.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63362

CERTIFICATE OF DEATH.

74-001

D 63362

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 E Fairmount Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Bennett

(a) RESIDENCE No. 2010 E Fairmount Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Automobile Business

(c) Name of employer La Porte Motor Company

9 BIRTHPLACE (city or town) (State or country) Gabrielenop Russia

PARENTS

10 NAME OF FATHER Jacob B.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Wallach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Abe Bennett 2010 E Fairmount Ave

15 Filed APR 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to April 10, 1922, that I last saw him alive on April 10, 1922, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? yes (Dr. Baggs[illegible])

(Signed) A. H. A. Mayer, M. D.

11-11, 1922 (Address) 2438 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave DATE OF BURIAL 4/11 1922

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 63363

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 E Madison ST.; 7 WARD)

2-FULL NAME Caroline Dorsey

(a) RESIDENCE. NO. 1625 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	/	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. city.

PARENTS

10 NAME OF FATHER Rufus Dansberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto city

12 MAIDEN NAME OF MOTHER Lydia Bias

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Lydia Skinner
(Address) 1625 E Madison St

15 Filed ....., 19 .....

APR 1 1922 ROBERT N. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-16, 1922, to Apr 10, 1922; that I last saw h alive on April 8, 19..; and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

one yr (duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) ....yrs. 3 mos. ....ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher, M. D.

4/10 1922 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	4/12/22 1922
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Mad st

TION is very important. See instructions on back of certificates.

Spec.—6.9.19—H. P. Co.—1000 Bks.

D 63364

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 09 63364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Richardson

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 APR 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to April 9, 1922, that I last saw h~~e~~r alive on April 8, 1922, and that death occurred, on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

4/10/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Apr 12 1922

20 UNDERTAKER: Chas G Bailey

ADDRESS: 1426 Jefferson St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63365

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Perry ST.: 4 WARD)

2-FULL NAME Sarah Fisher

(a) RESIDENCE. NO. 407 Perry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Newman

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook (Col)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER ~~Jacob~~ Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Joshua Johnson

(Address) 407 Perry.

15 Filed APR 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit No.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9 19 22

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1922, to April 9, 1922, that I last saw h Ealive on April 8, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Urinalysis

What test confirmed diagnosis?

(Signed) H. S. McCard, M. D.

, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Evergreen Cemetery	Apl 12 1922

20 UNDERTAKER ADDRESS

Wm Gaither Hafer 406 N Conway St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63366

CERTIFICATE OF DEATH.

90

D 63366

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 N. Paterson Park Ave. 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A. Malone

(a) RESIDENCE No. 1928 N. Paterson Park Ave ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James R. Malone

6 DATE OF BIRTH (month, day, and year): June 15/1884

7 AGE: Years 37 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Gilroy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen Gary.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): James R. Malone. 1928 N. Paterson ave

15 APR 11 1922 ROBERT A. KRAUTER, Registrar

BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4 - 9 - 1922

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1922, to 4 - 9 -, 1922, that I last saw h er alive on 4 - 8 -, 1922, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? None

What test confirmed diagnosis? Usual Symptoms

(Signed) E. Wales Wheeler, M. D.

4-10-1922 (Address) 2129 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: April 12 1922

X UNDERTAKER: George L. Ruth

ADDRESS: 1235 Hayford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.--1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63367 ✓

D 63367

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Garrison Avenue ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Garrison Fluharty.

(a) RESIDENCE. NO. 2306 Garrison Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Georgianna Flynn

6 DATE OF BIRTH (month, day, and year): Oct. 1, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	8	

8 OCCUPATION OF DECEASED

043

(a) Trade, profession or particular kind of work: Retired-Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer): Liquor Dealer

(c) Name of ~~Employer~~ FIRM: Lambdin & Thompson

9 BIRTHPLACE (city or town) Caroline Co.,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel H. Fluharty

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Todd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant: Mrs. Georgianna Fluharty
(Address) 2306 Garrison Avenue

15 Filed APR 11 1922, 19 ROBERT R. KRAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1922, to April 9th, 1922, that I last saw h[illegible] alive on April 9th, 1922, and that death occurred, on the date stated above, at 8-50 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of right tonsil and right side of neck

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Not Known

(duration) Not Known yrs. Not Known mos. Not Known ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Emmert Bradley, M. D.

4. 10 1922 (Address) 830 W. Monte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	4/12, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 63368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63368

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 W. Mulberry ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Steele

(a) RESIDENCE. No. 1419 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced: HUSBAND of ~~(or) WIFE of~~ Philip Steele

6 DATE OF BIRTH (month, day, and year) Aug. 12 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Tralee County Kerry Ireland

PARENTS

10 NAME OF FATHER: Nicholas Mullins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Philip Steele

(Address): 1419 W. Mulberry St

1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1921, to April 10th, 1922, that I last saw her alive on April, 1922, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Metastases into Brain from breast (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Dec 8 1921

Was there an autopsy? no

What test confirmed diagnosis? Physical & Operative

(Signed) J. H. C. Clift, M. D.

4/10, 1922 (Address) 1312 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 4/12 1922

20 UNDERTAKER: J. J. Fahey & Sons

ADDRESS: 1318 Eutaw

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 63369

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 W Randall ST., 23 WARD)

2-FULL NAME Mary Elizabeth Wright

(a) RESIDENCE No. 12 W Randall ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron J Wright

6 DATE OF BIRTH (month, day, and year) Aug 12 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Bates Co. (State or country) Mo

PARENTS

10 NAME OF FATHER W W Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elvira Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mudd (Address) 12 W Randall

15 Filed , 19 Registrar

Robert P. Marrion,

1 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to April 7, 1922,

that I last saw her alive on April 7, 1922,

and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about 3 yrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Jacob Taberman, M.D.

4/10/22 (Address) 1412 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 19

20 UNDERTAKER H Buckmaster Son

ADDRESS

D 63370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63370

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Removed dead Mercy Hospital 3 ST.: 31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Espal

(Residence in Baltimore: No. 832 Pratt St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	?

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

886

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert F. Marriden,

Filed ..... 19.... Burial Permit Clerk. Registrar.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Apr. 3, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Palmar hernia Left

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Apr. 8, 1922 (Address) 1639 Druid Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY.	....., 19....
20-UNDERTAKER Commissioner Health,	ADDRESS APR 11 1922

Dep. Wm. S. Woodall

important. See instructions on back of certificate.

R11 1922

D 63371

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-005

36 D 63371

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frank Kornecki

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, March (Month) ....., 1887 (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Klaus Kurn

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hospital

(Address) Balto. Md.

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

R 11 [illegible]

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 20, (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Kidney

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Hemmeter M. D.
(Coroner.)

April 10, 1922 (Address) 220 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY.

DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health,

ADDRESS APR 11 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

no relatives in this country. Could be gained from him by hypnotic authority

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

D 63372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 63372

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 608 Eisleben ST.: 22 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sherry

(Residence in Baltimore: No. 608 Eisleben St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colrd

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Sngle

6-DATE OF BIRTH, Dont Know (Month) (Day) 1 (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Sherry

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Laura Smith

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Sherry

(Address) [illegible]

15-

Filed [illegible], 191

Registrar.

11 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

4-11, 1922 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem | DATE OF BURIAL, April 12 1922

20-UNDERTAKER Brown & Freeland | ADDRESS 114 N Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1459 D 63373

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Katherine Michael

(a) RESIDENCE NO. 904 Wood Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Wilbur Michael

6 DATE OF BIRTH (month, day, and year) April 13 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife 307

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Westminster (State or country) Maryland.

10 NAME OF FATHER Charles Stoner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary C Geiman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Wilbur Michael (Address) 904 N Chester St

15 Filed , 19 Robert F. Harrison, Registrar

1822 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11. 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 11, 1922, that I last saw h[illegible] alive on April 11, 1922, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Ectopic Pregnancy.

Hemmorhage.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 904 Wood Chester

Did an operation precede death? Yes Date of April 6. 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) John W Michael, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Keiders Westminster — DATE OF BURIAL 4/13 19 22

20 UNDERTAKER J H Bankard & Son — ADDRESS Westminster

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63374

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Etting St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno. W. Pemberton

(a) RESIDENCE. (No. 2204 Etting St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 8, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Edward Pemberton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John W. Pemberton Jr. 2204 Etting St.

15 Filed . 19 Burial Permit Clerk. Registrar

11 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1922

17 I HEREBY CERTIFY, That I attended deceased from 3/6 , 19 22 , to 4/10 , 19 22

that I last saw h alive on 4/10 , 19 22

and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis + uremia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Rhett, M. D.

, 19 (Address) 3137 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Apl 13, 1922
20 UNDERTAKER	ADDRESS 1303
Frank H. Deford	Baltimore.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-001 D 63375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Fleet ST., 1 WARD)

2-FULL NAME Mary Stendzienska

(a) RESIDENCE NO. 2226 Fleet St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Stendzienski

6 DATE OF BIRTH (month, day, and year): 1845

7 AGE: Years 77 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Walenty Stefanski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Dont Knew.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Stanislaus Gratecki

(Address) 2226 Fleet St.

APR 11 1922 Filed, 19 Robert F. Hartman, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1922, to Apr 10, 1922, that I last saw her alive on Apr 9, 1922, and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary): Left Hemiplegia

(duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theophil Lawentown M. D.

(Address) 2129 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem.,

DATE OF BURIAL: April 12. 1922

20 UNDERTAKER: M. J. Sadowski

ADDRESS: 405 S. Ann St.

CAUSE OF DEATH must be plainly written, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not apoplectic. Cause
of hemiplegia unknown.
No hemorrhage

(Stella Malczewski) V

D 63376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63376

CERTIFICATE OF DEATH.

Registered No. C 167

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3043 Elliott St., 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stella Malczewski

(Residence in Baltimore: No.) 3043 Elliott St. (Yes) St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Nov. (Month) 13 (Day) 1903 (Year)

7-AGE: 18 yrs. 6 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Jacob Jaczkowski

11-BIRTHPLACE OF FATHER, (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER, (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michal Malczewski

(Address) 3043 Elliott St

15-

Filed ..... 192.....

Registrar.

1922 Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: April (Month) 10 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Ill. Gas.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Blades M. D.

(Coroner)

192 2 (Address) 1431 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: April 12 192 2

20-UNDERTAKER: Stephen L Fralkowski ADDRESS 1000 N Kenwood Ave

is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T—1500 Bks.

D 63377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63377

CERTIFICATE OF DEATH.

159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1637 Montpelier ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of August & Veronica Hildebrand

(a) RESIDENCE No. 1637 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Lyfl yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Hildebrand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Veronica Berg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant August Hildebrand (Address) 1637 Montpelier St

15 Filed ..., 19 Registrar

1922 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 8, 1922, to Apr 11, 1922, that I last saw her alive on Apr 10, 1922, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation Heart.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

4/11, 1922 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	April 6 1922
20 UNDERTAKER	ADDRESS
Jno L. Miller	2834 Jeffers

CAUSE OF DEATH. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Use ink and write in plain terms, so that it may be properly classified.

D 63378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 63378

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 348 S. Smallwood St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edward Beckman

(Residence in Baltimore: No. 348 S. Smallwood st 58 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: mal

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): widower

6-DATE OF BIRTH: dec (Month) 10 (Day) 63 (Year)

7-AGE: 58 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer OH
(b) General nature of Industry, business, or establishment in which employed (or employer): City Water Dept

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Beckman

11-BIRTHPLACE OF FATHER, (State or Country): maryland

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER, (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claudia Zanzow

(Address) 348 S. Smallwood st

15-

Filed 4-11 1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 10 (Day) 22 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of heart

Fatty degeneration (Duration) 1 yrs. 3 mos. ds.

(Signed) James R. Fuller M. D. (Coroner.)

4/10 1922 (Address) 700 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Pk Cem — DATE OF BURIAL: April 12 1922

20-UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 N. Balto St

Is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63379

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A. Kelly Hospital Inc. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Thomas V. Boardman.

(a) RESIDENCE. NO. St. Paul Apts. - City. ST., WARD. Elkridge Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Randolph Boardman

6 DATE OF BIRTH (month, day, and year): Jan 30th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturer 145

(b) General nature of industry, business, or establishment in which employed (or employer): Auto Truck Bodies

(c) Name of employer: Jones Boardman Corp.

9 BIRTHPLACE (city or town) (State or country): Greensboro Ala

PARENTS

10 NAME OF FATHER: Henry Boardman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greensboro, Ala.

12 MAIDEN NAME OF MOTHER: Carrie Osborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greensboro, Ala.

14 Informant: Mrs Ontria Randolph Boardman (Address) St Paul Apartments

15 Filed ....., 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10 1922.

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to April 10, 1922, that I last saw h[illegible] alive on April 10, 1922, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx.

about (duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of ? 3 mos ago

Was there an autopsy? No.

What test confirmed diagnosis? Pathological Exam.

(Signed) Arthur C. Friswood M. D.

4/10 1922 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Creek cemetery Washington D.C. DATE OF BURIAL: April 12 1922

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. North ave

11 1922

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63380 — CERTIFICATE OF DEATH — 31 — D 63380

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 11 Penn St ST.: 4 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Petuna Jackson

(Residence in Baltimore: No. 11 Penn St ST.: yrs. 5 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct (Month) 31 (Day), 1900 (Year)

7 AGE: 21 yrs. 5 mos. 9 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto

PARENTS

10 NAME OF FATHER: E B Jackson

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Worton

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eddie Jackson
(Address) 11 Penn St

15 Filed APR 12 1922 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 9 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1921, to Apr 9 1922, that I saw h[illegible] alive on Apr 9, 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Harry D. McCarthy M. D.

April, 1922 (Address) 37 W. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Apr 12, 1922

20 UNDERTAKER: Samuel Heaney — ADDRESS: 598 W Lexington

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63381

CERTIFICATE OF DEATH.

5 | D 63381

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Boston

(Residence in Baltimore: No. 702 N. Saratoga St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, Unknown ..... (Month), ... (Day), 1876 (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Martha A Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Boston

(Address) 702 Saratoga St

15- APR 12 1922 ROBERT R. KRAUTER, Filed....., 191..... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 28 1922, to April 5 1922, that I saw h... alive on April 5 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

Cardiac

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Abscess

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) F Mowell M. D.

April 10, 1922 (Address) 939 N. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem, DATE OF BURIAL, Apr 11 1922

20-UNDERTAKER Samuel Heuisler, ADDRESS 5[illegible] Bdle

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63382

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 E Pratt ST., 3 WARD)

2-FULL NAME Abraham Blum

(a) RESIDENCE NO. 1500 E. Pratt St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 01 3

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Bloom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Sophia Bloom

(Address) 1500 E Pratt St

15 FILED APR 12 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to April 11, 1922, that I last saw him alive on April 11, 1922, and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) ..... yrs. ..... mos. 1 day

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Smelt, M. D.

4/12, 1922 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 4/12 1922

20 UNDERTAKER Map Levinson — ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63383

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 63383

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Miller or Mueller.

(a) RESIDENCE. No. Bay View Asylum. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1922

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1919, to April 11, 1922, that I last saw her alive on April 10, 1922, and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D

4-11 1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed APR 12 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Apr 13 1922

20 UNDERTAKER: J Herzog & Co

ADDRESS: 2008 Eastern

USE OF DEATH in plain type, without abbreviations. Cause of puerperal cases. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Finch

D 63384

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101

001

D 63384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS H SPITAL. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Finch

(a) RESIDENCE NO. Kenyon ST., WARD Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 30/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Finch

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Ruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed APR 12 1922 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11th 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 10th 19 22 to April 11th 19 22.

that I last saw he alive on April 11th 19 22

and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home, (Riderwood)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J B Gay, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bal Cemetery

DATE OF BURIAL Apl 13 19 22

20 UNDERTAKER Robt Turner Sons

ADDRESS 1 & 2 Bway

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63385

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 N. Broadway ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria alice Campbell

(a) RESIDENCE. No. 1728 N Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1.30 pm

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev John P. Campbell

6 DATE OF BIRTH (month, day, and year) Dec 2. 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None — 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Salisbury, md Maryland

PARENTS

10 NAME OF FATHER William Freeny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie M. Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rev. John P. Campbell (Address) 1728 N. Broadway

15 Filed APR 12 1922 J. Elliott Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from December, 1921, to April 11, 1922, that I last saw h[illegible] alive on April 10. 1922, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis: Urine, Blood Examination

(Signed) W R Engman M. D.

, 19 (Address) 1429 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Caledonia, New York	April 14 1922
20 UNDERTAKER	ADDRESS
John B Spence	1325 N. Caroline St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61-D 63386

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1418 Clarkson St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Abbott

(a) RESIDENCE. No. 1418 E Clarkson St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General natore of industry, business, or establishment in which employed (or employer): 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John E. Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Florence Hulse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: John E. Abbott
(Address) 1418 E Clarkson St

15 Filed APR 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 29, 1922, to April 9, 1922

that I last saw h[illegible] alive on April 9, 1922

and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH was as follows:*

Acute Cardiac Dilatation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hartman M. D.

April, 1922 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Apr. 12 1922
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly due to lead poisoning. Occupation painter

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 63387

CERTIFICATE OF DEATH.

-161- D 63387

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Arbutus ave Lakeland ST. 25 WARD)

2-FULL NAME Infant of John Spector & Mary Kuch.

(a) RESIDENCE. NO. Arbutus ave Lakeland WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant (6 mo)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) April 10, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	no	no	no	2 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John Spector

11 BIRTHPLACE OF FATHER (city or town) (State or country) pa

12 MAIDEN NAME OF MOTHER Mary Kuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mary Kuch
(Address) Lakeland

15 Filed APR 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922 to April 10, 1922, that I last saw him alive on April 10, 1922, and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 mo.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? premature Birth

(Signed) R. D. Gilmore, M. D.

, 19 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL April 12

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1 Fort Ave

TION is very important. See instructions on back of certificates.

D 63388

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 63388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 805 Elm Alley ST.: 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Johnson

(Residence in Baltimore: No. 805 Elm alley St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Sept. 9, 1892
(Month) (Day) (Year)

7-AGE, 30 yrs. 7 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... (0)

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Chas. Taylor

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Boston

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Johnson

(Address) 805 Elm Alley

15- APR 12 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 12 1922 (Address) 2302 Eutaw pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, APR 12 1922

20-UNDERTAKER Samuel J. Lemmon — ADDRESS 5[illegible] Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63389 13-4464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 63389
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS H SPITL ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Hougwell.

(a) RESIDENCE NO. 2374 Hollins St. City. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Mrs. Powers (nurse),

6 DATE OF BIRTH (month, day, and year): Sept 29, 1921.

7 AGE — Years: 1 — Months: 6 — Days: 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: ---

9 BIRTHPLACE (city or town): ?
(State or country): ?

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town): ?
(State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town): ?
(State or country): ?

14 Informant: JOHNS HOPKINS H SPITAL.
(Address): Baltimore

Filed APR 12 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1922. to April 7th 1922.
that I last saw him alive on April 7th, 1922,
and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Stool cultures.

(Signed) Horace B. Stewart, M. D.

4/8, 19 22 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: APR 1922

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH must be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63390

CERTIFICATE OF DEATH.

90

REGISTERED NO. C D 63390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N Schroeder St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Powell

(Residence in Baltimore: No. 206 N Schroeder St.; 44 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, — (Month) — (Day) 1 (Year)

7-AGE, 57 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Aaron Cornish

11-BIRTHPLACE OF FATHER (State or Country), in Md

12-MAIDEN NAME OF MOTHER Sarah J Cornish

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena White

(Address) 206 N Schroeder

15- Filed APR 12 1922, 191.... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1921, to April 10 1922, that I saw h alive on April 10 1922, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cystitis Disease of Heart

(Duration) .... yrs. 6 mos. .... ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(Duration) .... yrs. .... mos. 1 ds.

(Signed) L. H. Norwood M. D.

April 11, 1922 (Address) 939 Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, April 13 1922

20-UNDERTAKER Wm Robert & Elliott | ADDRESS 1725 Ashland Ave

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63391 153 D 63391

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6 WARD)

2-FULL NAME Dorothy Coldfield

(a) RESIDENCE NO. 1541 Orleans St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? ~~yrs.~~ ~~mos.~~ ~~ds.~~

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of: Sallie Coldfield (mother) same address.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: X 2 | Months: ? | Days: ? | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. POD

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town): Unknown

(State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country): Unknown

14 Informant: JOHNS HOPKINS HOSPITAL

(Address): .....

15 Filed APR 12 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1922

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1922 to April 11, 1922

that I last saw her alive on April 11, 1922

and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of left arm

ACUTE

(duration) ..... yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Convulsions, Cause unknown

(duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of April 5 1922

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) Cleanthus Corbin, M. D.

4/12, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bury Cemetery — DATE OF BURIAL: April 14 1922

20 UNDERTAKER Edward Bryon — ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of abscess unknown. Best information physician could give. Autopsy refused. No further history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63392

D 63392

CERTIFICATE OF DEATH.

10

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 222 N Schroder ST.: 18 WARD)

2-FULL NAME James Addison Scotten

(a) RESIDENCE. NO. 222 N Schroder ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Scotten

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sparrows Point, North Carolina

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Jas Scotten

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Isabelle Scotten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Isabelle Scotten

(Address) 222 N Schroder St

15 Filed 1 2 1922 Robert F. Hartman Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr - 11 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27 - 1922, to Apr - 11 - 1922

that I last saw him alive on Apr - 11 - 1922.

and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Neurits
with acute Cardiac Dilatation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Diphtheria

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Cannot Say

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Throat Cultures of Streptococ

(Signed) Edw Shorr, M. D.

4/12 1922 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashbury N. Carolina	April 19 22

20 UNDERTAKER Brown & Freeland ADDRESS 1401 Gilmore St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63393

CERTIFICATE OF DEATH.

100-001 D 63393

1-PLACE OF DEATH 308 Princeton St. 12

CITY OF BALTIMORE: (No. 2 ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Taylor.

(a) RESIDENCE. No. 308 Princeton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1882

7 AGE — Years: 29 | Months: 6 | Days: 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 041

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexander Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Phill Smith
(Address) 308 Princeton Pl.

15 Filed APR 12 1922 . 19 J E Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1 . 19 22 . to April 10 . 19 22 .
that I last saw h alive on April 9 . 19 22 .
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jacus A. Johnson, M. D.

. 19 (Address) 21-E-Mt Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md | DATE OF BURIAL: April 12 19 22

20 UNDERTAKER: George H. Holland | ADDRESS: 163 W Baltimore

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

154483.
D 63394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63394

CERTIFICATE OF DEATH.

147

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS H ST. 14 WARD)

2-FULL NAME Pauline Scott

(a) RESIDENCE No. 561 Lanvale St City WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Moses Scott

6 DATE OF BIRTH (month, day, and year) Feb 24-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	25	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS H'SPITAL (Address) Lecanto

15 Filed APR 12 1922 J. H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch. 14th, 1922, to April 11, 1922, that I last saw her alive on April 11, 1922, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Thrombo-phlebitis post-partum.
Abscess formation
Secondary Anaemia
(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Operative Shock
(duration) yrs. mos. 1/2 hr. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 3-15-22, 3-25-22, 4-11-22

Was there an autopsy? Yes

What test confirmed diagnosis? Operative + Autopsy Findings

(Signed) M M Zumminger, M. D.

4-12, 1922 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md Auburn Cem | DATE OF BURIAL Apr 12, 1922

20 UNDERTAKER George H Holland | ADDRESS 1631 Orchard Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63395 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63395

CERTIFICATE OF DEATH. 179 Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Bay View Hospital St..... Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Fickes

(Residence in Baltimore: No. 1140 Aikenside St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	White	Single

6-DATE OF BIRTH. Not Known (Month) (Day) 1..... (Year)

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seaman
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country). Chicago Ill.

PARENTS.

10-NAME OF FATHER. —

11-BIRTHPLACE OF FATHER, (State or Country). —

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER, (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bay View Hospital
(Address)

15- Robert F. Harrison, U.
Apr 12 1922 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr 4 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 1 ds.

(Signed) J C Wades M. D.
(Coroner)
Apr 11 192 2 (Address) 143 E Bray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. 19

20-UNDERTAKER. Commissioner Health. ADDRESS APR 12 1922

19104 THE MORGUE

is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63396

CERTIFICATE OF DEATH.

45

D 63396

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Homewood Hospital St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia R. Toland

(a) RESIDENCE. No. 1102 Harlem Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Toland

6 DATE OF BIRTH (month, day, and year) Nov., 30th. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Frederick F. Diether

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Summer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Cooney

(Address) 1102 Harlem Ave

15 Filed ..., 19... Registrar

1 2 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 19

17 I HEREBY CERTIFY, That I attended deceased from April 7 19 22 to April 10 19 22

that I last saw h[illegible]ive on April 10 19 22

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (secondary) Obstruction of Bowel, Ileus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1102 Harlem

Did an operation precede death? yes Date of April 9/22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Ino F Diether M. D.

19 (Address) 2924 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ivy Hill Cem. Germantown Pa.	4/13/22 19
20 UNDERTAKER	ADDRESS
CHAS. F. Evans & Son	118 W. Mt Royal Ave

TION is very important. See instructions on back of certificates.

D 63397

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 63397

1 PLACE OF DEATH

REGISTERED No. C 118, 26

CITY OF BALTIMORE (No. 3413 E Baltimore ST.; WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Nellie E Whalen

(Residence in Baltimore: No. 3413 E Baltimore St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May (Month) 9 (Day), 1 (Year)

7 AGE: 23 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Harry E Wallett

11 BIRTHPLACE OF FATHER (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Willitta Dorrida

13 BIRTHPLACE OF MOTHER (State or country): Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J Whalen

(Address) 3413 E Balto st

15 Filed 1922, 191

Robert P. Harrison,
Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 11 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to April 11 1922
that I saw her alive on April 11, 1922
and that death occurred, on the date stated above, at 10 4 m.
The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) Uremia. Convulsions

(Duration) yrs. mos. 1 ds.

(Signed) J W Whalen M. D.

April 14, 1922 (Address) 330 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Mary's Cem Lampeter — DATE OF BURIAL: April 13, 1922

20 UNDERTAKER: Harry H. Watzke — ADDRESS: 1531 W. Lombard st

R1 2 1922

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No further history.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train — accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63398

CERTIFICATE OF DEATH.

167-001 D 63398

1-PLACE OF DEATH Robert Garrett Hospital for Children REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Stokes

(a) RESIDENCE NO. 1337 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) MOR 10-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	—	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Le Roy Lowenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Lusk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Elizabeth Stokes (Address) 1372 N. Gilmor St

15 Filed 1 2 1922 Robert P. Harriden, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17 I HEREBY CERTIFY, That I attended deceased from April 9th, 1922, to April 12, 1922, that I last saw him alive on April 11, 1922, and that death occurred, on the date stated above, at 10 05 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible] Clerk, M. D.

4/12 1922 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Apr 13 1922

20 UNDERTAKER George J Smith ADDRESS 1000 Fayette

INSTRUCTIONS.—Exact statement of OCCUPATION is very important. See instructions on back of certificates. Answer all questions in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63399

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Penna. Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Irine Bryan

(a) RESIDENCE. No. 1107 Penna. Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-24-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Centerville, Md.

PARENTS

10 NAME OF FATHER Perry Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Centerville Md.

12 MAIDEN NAME OF MOTHER Ida Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Centerville, Md.

14 Informant Ida Bryan, Mother
(Address) 1107 Penna. Ave.

15 Filed 12 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-8, 1922, to 4-10, 1922, that I last saw h[illegible] alive on 4-10, 1922, and that death occurred, on the date stated above, at 6:45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 20 1922
20 UNDERTAKER David Easton	ADDRESS 916 Pa ave

TION is very important. See instructions on back of certificates.

Stec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63400

CERTIFICATE OF DEATH.

74-001 D 63400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Reservoir St Park Ave St.: 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Lennox Bond Jr

(a) RESIDENCE. No. Reservoir St & Park Ave St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~: Mrs Jessie Van Rensselaer Dod Bond

6 DATE OF BIRTH (month, day, and year): Dec 23rd 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R

(c) Name of employer: B & O R R

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Hugh Lennox Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Annie Penniman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mrs H. S. Bergland Wilmington Del.

15 Filed . 19 ROBERT R. KRAUTER Registrar

APR 13 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from . 1910 . to April 11 . 1922, that I last saw him alive on April 11 . 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism (Hemorrhage) 23 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual tests

(Signed) Robert Shiels, M. D.

April 12 1922 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 13 1922
20 UNDERTAKER	ADDRESS
Henry Perkins & Son Inc	Broadway & Galler

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63401

CERTIFICATE OF DEATH.

74-006 D 63401

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 135 W. Henrietta ST.: 73 WARD:

2-FULL NAME Joseph H. Sewell

(a) RESIDENCE. NO. 135 W. Henrietta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaiah Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harriett Sewell
(Address) 914 Gaudenhall St

15 Filed APR 13 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1 1922 to April 11 1922, that I last saw h[illegible] alive on April 11 1922 and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

(a) Paralysis Cerebral Hemiplegia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. F. Finch, M. D.

(Address) 712 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL April 14 1922

20 UNDERTAKER John H. Toadvine

ADDRESS 142 Hanover St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63402

CERTIFICATE OF DEATH.

179 D 63402

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 S. Carey ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Ralston

(Residence in Baltimore: No. 29 S. Carey St.; Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan. (Month) (Day) 1860 (Year)

7-AGE, 62 yrs. 3 mos. – ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer). 031

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Jas. H. Ralston

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary J. Hamilton

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Ralston

(Address) 29 S. Carey

15- Filed APR 13 1922, 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 11 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3, 1921, to Apr 11 1922, that I saw him alive on Apr 11 – 1922, and that death occurred, on the date stated above, at 7-50 A m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

(Duration) 4 yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) Over 4 mos. 5 ds.

(Signed) Thomas E. Bell M. D.

Apr 11, 1922 (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 4/14, 1922

20-UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto. St.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Crook.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63403

CERTIFICATE OF DEATH.

154 D 63403

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 W North Av ST.; 15 WARD)

2-FULL NAME Betty L. Crook

(a) RESIDENCE NO. 1636 W North av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE Wht | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 11/22

7 AGE Years Months Days One | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 1636 W North Av. (State or country)

PARENTS

10 NAME OF FATHER Henry W. Crook

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country)

12 MAIDEN NAME OF MOTHER Viola Coates

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Henry W Crook (Address) 1636 W North Ave

15 Filed APR 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1922 to Apr. 12, 1922, that I last saw her alive on Apr. 12, 1922, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Malformation (acephalus

(duration) yrs. mos One ds.

CONTRIBUTORY (Secondary) Madness

(duration) yrs. mos One ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E. L. Smith M. D.

4/12 1922 (Address) 1636 W. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden | DATE OF BURIAL Apl 13 1922

20 UNDERTAKER Chenoweth & Son | ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63404

CERTIFICATE OF DEATH.

31 D 63404

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 S. Green St. (Ward) 22

2-FULL NAME Joseph Powell

(a) RESIDENCE. No. 703 S Green St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Powell

6 DATE OF BIRTH (month, day, and year) March 26-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Powell (Address) 703 S Green St

15 FILED APR 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1921, to April 11, 1922, that I last saw h. alive on April 8, 1922 and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. 3 mos. 25 ds.

CONTRIBUTORY (Secondary) As above

(duration) yrs. 3 mos. 25 ds.

18 Where was disease contracted if not at place of death? As above

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

April 11 1922 (Address) 712 S Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 19
20 UNDERTAKER	ADDRESS
S. S. Prouty & Son	[illegible]

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63405

CERTIFICATE OF DEATH.

179

D 63405

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1373 N. Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Henry Wallace

(a) RESIDENCE. No. 1373 N Carey ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Wallace

6 DATE OF BIRTH (month, day, and year) 1858, March 2

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoedover 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Merchant & Miners Calvert Co

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thomas Henry Wallace

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or country)

14 Informant Maud Jones

(Address) 1373 N. Carey

15 Filed APR 13 1922 19 ROBERT R. KRAUSER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 9 1921, to April 12 1922, that I last saw h alive on April 11 1922, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure in Cafexia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary & Physical

(Signed) William N. Wright M. D.

April 12 1922 (Address) 1209 Presbman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	April 16 1922
20 UNDERTAKER	ADDRESS
Hammond & Wright	Cumberland

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63406

CERTIFICATE OF DEATH.

74-001

74 D 63406

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 Fleet ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Henry Ault

(a) RESIDENCE. NO. 2304 Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rickie Ault

6 DATE OF BIRTH (month, day, and year): Aug 29, 1860

7 AGE: Years 61 | Months 7 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 06V

(c) Name of employer: Standard Oil Co.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Conrad Ault.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henretta Ault.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Rickie Ault. (Address) 2304 Fleet St

15 Filed APR 13 1922, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1921, to April 11, 1922.

That I last saw him alive on April 11, 1922,

and that death occurred, on the date stated above, at 10.05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Charles S. Cook M. D.

4/11, 1922 (Address) 503 S Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	April 14 1922
20 UNDERTAKER: Robt S. Little	ADDRESS: 2700 Edmondson Av

THE LAW requires a certificate of death in each case before a burial permit can be issued, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 63407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 63407

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 W Lexington ST., 14 WARD)

2-FULL NAME Alma A Shipley

(a) RESIDENCE NO. 1531 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallace Shipley

6 DATE OF BIRTH (month, day, and year) Nov 8 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Shirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John T Shipley (Address) 2500 Kirk Ave

15 Filed APR 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1921 to April 11 1922.

that I last saw h[illegible] alive on April 10 1921,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interst. Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Mayer M. D.

4.12.1922 (Address) 801 W. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL April 14, 22

20 UNDERTAKER Wm Cook. — ADDRESS N & G Ave

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63408

D 63408

CERTIFICATE OF DEATH.

74

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1839 N. Chapel ST., 6 WARD)

2-FULL NAME Frank Gessner

(a) RESIDENCE NO. 1839 N. Chapel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Gessner

6 DATE OF BIRTH (month, day, and year) Feb 21, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General.

(c) Name of employer Crown Cork & Seal Co.
Balto Md

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER John N Gessner

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Frances Singer

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Wilhelmina Seitz
(Address) 1839 N Chapel St.

15 Filed APR 13 1922 ROBERT R. KRAUSE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1922

17 I HEREBY CERTIFY, That I attended deceased from February 24 1922 to Apr 11 1922,
that I last saw him alive on Apr 10 1922,
and that death occurred, on the date stated above, at 6 45a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. 1 mos 15 ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none but paralysis

(Signed) Thos. Fa Sheuren, M. D.

4/11, 1922 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 4/13 1922

20 UNDERTAKER William Cook — ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

E. C. Murray
1221 W Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

63409 D

CERTIFICATE OF DEATH.

D 63409

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Edmondson ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Thomason

(a) RESIDENCE NO. 1607 Edmonson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15-1843

7 AGE Years 78 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER S. W. Cayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mckown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant S. W. Thomason

(Address) 1607 Edmondson

15 Filed APR 13 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1921, to Apr 12, 1922

that I last saw her alive on Apr 12, 1922

and that death occurred, on the date stated above, at 12.20 P.M.

The CAUSE OF DEATH* was as follows:

Int. Interstitial Nephritis

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Olen Murray, M. D.

Apr. 13. 1922 (Address) 1221 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden South Carolina

DATE OF BURIAL 4/15 1922

20 UNDERTAKER William Cook

ADDRESS 502 E. Worth

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor's Inquiry

D 63410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63410

CERTIFICATE OF DEATH.

Registered No. C 8 90

1-PLACE OF DEATH

City of BALTIMORE (No. Johns Hopkins Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Henry R. Payne

(Residence in Baltimore: No. 1840 East Chase St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: May (Month) 13 (Day) 1880 (Year)

7-AGE: 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Stationary

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Henry O. Payne

11-BIRTHPLACE OF FATHER, (State or Country): Kent Co Md

12-MAIDEN NAME OF MOTHER: Margaret E. Baldwin

13-BIRTHPLACE OF MOTHER. (State or Country): Kent Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Payne

(Address) 1840 E. Chase

15-

Filed APR 13 1927 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11 (Day) 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

1927 (Address) [illegible]

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Apl 14 1927

20-UNDERTAKER: William Cook

ADDRESS: 502 E North

is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 63411

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 63411

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 863 Greenmount ST., 10th WARD)

2-FULL NAME Nicola Manfredi

(a) RESIDENCE No 863 Greenmount ave WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) —

6 DATE OF BIRTH (month, day, and year) ~~May 7 1920~~ May 7-1921

7 AGE 1 Years 11 Months 5 Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stefano Manfredi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Teresina D. Stefano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Stefano Manfredi

(Address) 863 Greenmount ave

15 Filed APR 13 1922 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 1922 to 4/12, 1922, that I last saw h. alive on 4/12, 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Measles

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Harry G. Eldor, M. D.

4/12 1922 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents Cemetery

DATE OF BURIAL 4/12 1922

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63412

CERTIFICATE OF DEATH.

113 D 63412

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Warner ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel May Wright

(a) RESIDENCE. No. 910 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Bryan Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Ophelia Giles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Bryan Wright
(Address) 910 Warner St.

15 Filed APR 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 9, 1922, to Apr 11th, 1922

that I last saw h— alive on Apr 11th, 1922

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D H Cameron, M. D.

4/13, 19 (Address) Towsontown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	4/13 1922
20 UNDERTAKER	ADDRESS
Wm H Hooper	406 N Carey St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 63413

CERTIFICATE OF DEATH.

74 D 63413

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 W. Saratoga ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Welsh

(a) RESIDENCE. No. 2024 W Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Welsh.

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60.	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr John Welsh
(Address) 2024 W Saratoga St.

15 APR 13 1922 ROBERT R. DAUB, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to April 11, 1922, that I last saw him alive on April 11, 1922, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw. J. Coolahan, M. D.

4/13 1922 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 14 1922
20 UNDERTAKER James F. Cowan & Son, Per F.J. Cowan	ADDRESS 901 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63414

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 63414

REGISTERED NO. C 129

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Forest Ave ST. Near Windsor Ave Rd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Ann Musser

(Residence in Baltimore: No. Forest Ave St.; 81 yrs. 5 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6-DATE OF BIRTH: May (Month) 18 (Day) 1840 (Year)

7-AGE: 81 yrs. 5 mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): New York

PARENTS

10-NAME OF FATHER: George H Holt

11-BIRTHPLACE OF FATHER (State or country): Concord

12-MAIDEN NAME OF MOTHER: Elizabeth Heat

13-BIRTHPLACE OF MOTHER (State or country): Vermont

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Marsh

(Address) Forest ave

15- Filed APR 13 1922, 191 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 12 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 12 1922, that I saw h.. alive on April 11 1922, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

(Signed) Louis Ebaugh M. D.

April 13, 1922 [Address] 710 W Fayette Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: April 14th 1922

20-UNDERTAKER: W. W. Shriver

ADDRESS: 1018 Edmondson Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Cornelia Friend

D 63415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63415

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 Biddle ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorneau Friend

(a) RESIDENCE NO. 429 Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Friend

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 57 – Months – Days – If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer: –

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Harry Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Polly Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Husband 709 W. Lanvale St.

15 Filed APR 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from February 10th 1922 to April 10th 1922

that I last saw her alive on April 10th 1922

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hardening of arteries

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of –

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Ellis, M. D.

4/12 1922 (Address) 924 Mad

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: April 13 1922

20 UNDERTAKER: Samuel T. Hemsley

ADDRESS 516 W. Biddle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63416 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

113 D 63416

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2666 Wilkins Av. ST., 20 WARD)

2-FULL NAME Eleanore M. Keller

(a) RESIDENCE NO. 2666 Wilkins av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE Wht | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 5th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	6	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ....nod

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Jno H Keller

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Etta D Rotaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) European Md.

14 Informant Jno. H. Keller (Address) 2666 Wilkins av

15 APR 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1922, to Apr. 11, 1922, that I last saw h[illegible] alive on Apr 10, 1922 and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Dyspepsia & severe Convulsions followed by Meningitis (Cerebral.)

(duration) yrs. mos 3 ds. 0127

CONTRIBUTORY (Secondary) Weakening of Heart & Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [signature] M. D.

4/11, 1922 (Address) 1605 N Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL Apr 14 1922

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal indigestion.
Convulsions seizure
& probably affected
brain. Not tuberculous

Spec.—1-10-21—M&T—1500 Bks.

Gamble.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63417

CERTIFICATE OF DEATH.

90 D 63417

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 W Lombard ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gamble

(a) RESIDENCE NO. 1422 Lombard ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Gamble

6 DATE OF BIRTH (month, day, and year) Aug 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) Charwoman

(c) Name of employer Emerson Drug Co

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Corrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Corrigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George H. Smith. (Address) 211 Penrose Ave.

15 FILED APR 13 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 8 1922, to April 4 1922, that I last saw h[illegible] alive on April 4 1922, and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray, M. D.

4-12, 1922 (Address) 510 N. Mimms ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: April 14 1922

20 UNDERTAKER: Wm J. Hartwell — ADDRESS 2236 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Turnt)

D 63418

HEALTH DEPARTMENT—CITY OF BALTIMORE

119 D 63418

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 70 WARD)

2-FULL NAME Mrs. Jennie Turnt

(a) RESIDENCE No. 500 N. Fulton ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Turnt

6 DATE OF BIRTH (month, day, and year) May 28-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ot. Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Louis L. Casper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Pauline Robier

(Address) 500 N. Fulton ave.

15 Filed APR 13 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 2, 19 22 to April 11, 19 22

that I last saw h er alive on April 11, 19 22,

and that death occurred, on the date stated above, at 6:30 p m.

The CAUSE OF DEATH* was as follows:

Prolapsus Recti

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ..... yrs. ..... mos. 9 ds.

18 Where was disease contracted (?) if not at place of death? .....

Did an operation precede death? yes Date of April 7 19 22

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) Cayetano Panettieri, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Apr. 14 1922

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63419 — 74-001 — D 63419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1047 Vine St. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leland Lewis

(Residence in Baltimore: No. 1047 Vine St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Mar'd

6-DATE OF BIRTH, (Month) Sept (Day) Known, (Year) 1869

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd Jobs

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Samuel Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Maria J. Scott

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie Lewis

(Address) 1615 N Fremont

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk Registrar.

1 31922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apl (Month) 13 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apl 10 1922, to Apl 13 1922, that I saw h alive on Apl 12 1922, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. Norwood M. D.

Apl 13, 1922 (Address) 739 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, 15, 1922

20-UNDERTAKER George A. Fiton ADDRESS 673 Lanvale 28

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63420

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 63420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4160 Belair Road WARD 7)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Wehr

(a) RESIDENCE. No. 4160 Belair Road. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J. Wehr

6 DATE OF BIRTH (month, day, and year) June 22 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dent Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) William F. Wehr 4160 Belair Road

15 Filed 1922 Robert [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1922, to Apr 12, 1922, that I last saw h[illegible] alive on " , 1922, and that death occurred, on the date stated above, at 9 2 m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Hemorrhage of brain)

March 21 (duration) yrs 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos D Corse, M. D.

, 19 (Address) Corse and Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	April 15 1922
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2178 Key

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63421

CERTIFICATE OF DEATH.

118-001

D 63421

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 332 S. Stricker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Ann Hatfield

(Residence in Baltimore: No. 332 S. Stricker St. St.; 10 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, January (Month) 22 (Day), 1840 (Year)

7-AGE, 82 yrs. 2 mos. 20 da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Carroll Co., Md.

PARENTS.

10-NAME OF FATHER, Alexandria Porter

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co. Md.

12-MAIDEN NAME OF MOTHER Nancy Zepp

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nancy Evans

(Address) 332 S. Stricker St.

15-

Filed ..... 1922 Harrison

Registrar.

1 3 1922 Burial Permit Clerk

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 3rd 1922, to April 11th 1922, that I saw her alive on April 11th 1922, and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

8 (Duration) .... yrs. .... mos. .... da.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) .... yrs. .... mos. 5 da.

(Signed) O. L. Nuckols M. D.

April 13, 1922 (Address) 130 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn Cem. Co. DATE OF BURIAL April 14, 1922

20-UNDERTAKER C. Jones ADDRESS 257 S. Arlington Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63422

D 63422

CERTIFICATE OF DEATH.

5 31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry Lee

(a) RESIDENCE. No. 141 N. High st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 9

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Corber

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Robert [illegible], 19

Registrar

Burial Permit Clerk.

1 3 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to April 11, 1922, that I last saw him alive on April 11, 1922, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Badagliacco M. D.

4-12, 1922 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL April 14 1922

20 UNDERTAKER Frank Enoch & Son

ADDRESS 1916 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63423

D 63423

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: N WARD)

2-FULL NAME James Burke

(a) RESIDENCE. NO. UNKNOWN ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

086

9 BIRTHPLACE (city or town) (State or country) Concord, Mass.

PARENTS

10 NAME OF FATHER Micheal Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Heale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 APR 13 1922 Registrar Robert P. Harrison, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 19 22

17 I HEREBY CERTIFY, That I attended deceased from November 9, 19 21, to April 10, 19 22.

that I last saw him alive on April 9, 19 22.

and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Varicose ulcer both legs.

(duration) 7 yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? signs and symptoms

(Signed) Ezequiel Martinez M. D.

4/10/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City N.Y.	April 18 19 22
20 UNDERTAKER Mc. Mos. 183 5th Ave	ADDRESS 183 5th Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

155082 63424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63424

CERTIFICATE OF DEATH.

21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford Fowlkes

(a) RESIDENCE NO. 701 Small ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mary Fowlkes

6 DATE OF BIRTH (month, day, and year) unknown 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James H. Fowlkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 APR 13 1922 , 19 Registrar (Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1922, to April 11, 1922

that I last saw him alive on April 11, 1922,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute pleurisy with effusion

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 71 Small St

Did an operation precede death? Yes Date of 4/10/22

Was there an autopsy? Yes

What test confirmed diagnosis? Culture

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Creve Va Station — DATE OF BURIAL Apr 14 1922

20 UNDERTAKER Edward Pinggold — ADDRESS 1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Streptococcus pleurisy.
Operation for drainage.

Spec.—1-10-21—M&T—1500 Bks.

D 63425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001 D 63425

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Smith St ST., 14 WARD)

2-FULL NAME Sterling Edwards

(a) RESIDENCE No. 630 Smith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Edwards

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
28	1894	July	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry 41

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredrick Co.

12 MAIDEN NAME OF MOTHER Jeanette McKeus

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore Md

14 Informant (Address) John H. Edwards 630 N. Smith St

15 Filed APR 3 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to April 11—, 1922, that I last saw him alive on April 11—, 1922 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. G. W. Kennard, M. D.

4-12-1922 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 14 1922
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey St

Spec.—1-10-21—M&T—1500 Bks.

1540 63426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 001 D 63426

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Moody

(a) RESIDENCE NO. 1114 Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1906

7 AGE: 16 years (Years / Months / Days)

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Welton Moody

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lena Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: JOHNS HOPKINS HOSPITAL Record

(Address)

15 [illegible] 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1922

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 12, 1922,

that I last saw h[illegible] alive on April 12, 1922,

and that death occurred, on the date stated above, at 11 55/4 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar (Clin)

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death? 1114 Carey St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray

(Signed) E. Cowles Andrus, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Essex Co. Va

DATE OF BURIAL: April 16 1922

20 UNDERTAKER: Edward Ringgold

ADDRESS: 1463 Carey

Apr 1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

By John.
Lobar Pneumonia found.
No Peritonitis.
Dr. Jones.
per RHK.

D 63427

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63427

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2609 Guilford ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clinton Shwearer

(Residence in Baltimore: No. 2609 Guilford ave St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) Unknown (Day) 1873 (Year)

7-AGE, 48 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Secty in Law Dept
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R Co

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Shwearer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Rachael Givens

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine A. Mussel

(Address) 1248 N. Broadway

15-

(Date) APR 13 1922, 191.....

Robert J. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

191.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, April 15 1922

20-UNDERTAKER Wm J. McKnew & Sons

ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 13 1922

Spec.—1-10-21—M&T—1500 Bks.

D 63428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63428

129

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2742 N. Calvert ST. 17 WARD)

2-FULL NAME Chas. Shields Jackins

(a) RESIDENCE NO. 2742 N. Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Jackins

6 DATE OF BIRTH (month, day, and year): May 7, 1871

7 AGE — Years: 50 — Months: 11 — Days: 5 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager Oil

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Hendler Creamery Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Jackins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Paris France

12 MAIDEN NAME OF MOTHER: Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Helen Jackins
(Address): 2742 N Calvert.

15 Filed: Robert P. Harrison, Registrar
R 13 1922
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 17 1922.

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1921, to April 17th, 1922, that I last saw him alive on April 11th, 1922, and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertrophy of Prostate
Chronic Interstitial Nephritis

Unknown (duration) yrs. mos ds.
Uremia

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray showed enlarged Prost. Blood urine Ex —

(Signed) Frederick D. Crom, M. D.

. 19 (Address) 2827 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Apr 14 1922

20 UNDERTAKER: Wm J. Tuckers Son — ADDRESS: North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63429

CERTIFICATE OF DEATH.

D 63429

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N Gay St ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ruth Fuller

(a) RESIDENCE NO. 1612 N Gay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilson T Fuller

6 DATE OF BIRTH (month, day, and year) July 20 1897

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
24	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur Burgee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret McKim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wilson T Fuller

(Address) 612 N Gay St

15 Filed , 19 Robert F. Harris Registrar

APR 8 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1922

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1922, to April 11, 1922, that I last saw her alive on April 11, 1922, and that death occurred, on the date stated above, at 7-20 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Lung Embolism

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) Leslie M Bliss M. D.

April 12 1922 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL April 14 1922

20 UNDERTAKER Wm Cook

ADDRESS N of Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 63430

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Barbara Huebschmann

(Residence in Baltimore: No. Old Ladies Home (St Josephs Hosp) St.; 55 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Huebschmann

(Address) 104 S. Wolfe

15- Filed APR 14 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 11 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 3 1922, to April 11 1922, that I saw her alive on April 11 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) Herman J. Dorf M. D.

April 12, 1922 (Address) St. Josephs Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	April 14 1922
20-UNDERTAKER	ADDRESS
Wendell Hippelheuser	37 S. Anne St

important. See instructions on back of certificate.

D 63431

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

D 63431

REGISTERED No. C 63431

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2331 Greenmount Ave ST.; 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John H. Edel

(Residence in Baltimore: No. 2331 Greenmount Ave St.; 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Unknown (Month), (Day), 1836 (Year)

7 AGE: 86 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor butter
(b) General nature of industry, business, or establishment in which employed (or employer):
080

9 BIRTHPLACE (State or country): Germany.

PARENTS

10 NAME OF FATHER: Philip Edel.

11 BIRTHPLACE OF FATHER (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary. Wells.

(Address) 1335 E North Ave

15 Filed APR 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 12 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 12 1922

that I saw h— alive on April 11, 1922

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

about 7 (Duration) yrs. mos. ds

Contributory (SECONDARY) Valvular heart

(Duration) yrs. 10 mos. ds.

(Signed) James M Perlow M. D.

April 13, 1922 (Address) York Road

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ~

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore.

DATE OF BURIAL: April 15 1922

20 UNDERTAKER: Leo. G. Cook

ADDRESS: North Stafford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63432

CERTIFICATE OF DEATH.

X 167 D 63432

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1021 W Baltimore St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Nathan Adelman

(Residence in Baltimore: No. 2545 McCulloh St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, (Month) Unknown (Day) (Year) 1.....

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cut Trimmer
(b) General nature of industry, business, or establishment in which employed (or employer) Place for Rubber

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. M. Adelman

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Tobie Adelman

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benj Adelman

(Address) Hartford Conn.

15-

Filed APR 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas Suicide

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Melancholia

(Duration) ... yrs. 1 mos. ... ds.

(Signed) James M. Fenton M. D. (Coroner.)

April 12 1922 (Address) 701 E Oliver St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hartford Conn.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 4/14 1922

20-UNDERTAKER, A. Levinson & Bro — ADDRESS 112 E. Balto St

PHYSICIAN OR PERSON IN CHARGE OF CASE: Please read carefully the instructions on back of certificate. Every question must be answered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63433 X 31 D 63433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Ft. McHenry U.S. V. Hosp. #58 Baltimore, Md.. REGISTERED NO.....

CITY OF BALTIMORE: (NO. ..... ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar L. Tallman

(a) RESIDENCE NO. Thomas, W. Va.. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. E.L. Tallman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) W. Va.. (State or country) -

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E.T. Rosenbrock (Address) Registrar

15 Filed APR 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 22

17

I HEREBY CERTIFY, That I attended deceased from 2/22/22, 19..., to 4/13/22, 19...,

that I last saw him alive on April 13, 19 22,

and that death occurred, on the date stated above, at 1.55 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far. adv. " active

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) -- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) H.B. Jones Surgeon USPHS M. D.

4/13 1922 (Address) Ft. McHenry, Md..

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thomas W. Va DATE OF BURIAL 4/14 1922

20 UNDERTAKER A. Simonson & Bro ADDRESS 1127 E. Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63434

CERTIFICATE OF DEATH.

qv D 63434

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 442 N. Luzerne Ave ST., 6 WARD)

2-FULL NAME Anna B. Kerber

(a) RESIDENCE NO. 442 N. Luzerne Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Kerber

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Eichmiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs George S. Lauman

(Address) 442 N. Luzerne Ave

15 Filed APR 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 12, 1922,

that I last saw h[illegible] alive on 11 12, 1922

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis of June.

(duration) ... yrs. ... mos 12 ds.

CONTRIBUTORY (Secondary) old age

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

4/12-1922 (Address) 2600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL April 15 1922

20 UNDERTAKER L. Sander Sons — ADDRESS 1700 Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63435

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3308 Evergreen Oak Ave ST., 15 WARD)

2-FULL NAME William Heil

(a) RESIDENCE NO. 3308 Evergreen Oak Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Heil

6 DATE OF BIRTH (month, day, and year) Jan. 28. 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Kaspar Heil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant J. W. Charles Heil (Address) 3308 Evergreen Oak ave

15 Filed APR 1 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922, to Apr 10th, 1922, that I last saw him alive on Apr 10th, 19, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus at Junction with Stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stricture of Oesophagus

(Signed) A. C. Samuel, M. D.

Apr 15 1922 (Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 12 1922
20 UNDERTAKER L. Sander Sons	ADDRESS 1210 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63436

D 63436

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Ashland Ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Seeman

(a) RESIDENCE NO. 2306 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 14 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Christian Seeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Attick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary C Fisher

(Address) 2306 Ashland ave

15 DATE RECEIVED APR 14 1922

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 1, 19 22, to April 13, 19 22.

that I last saw h alive on April 12, 19 22,

and that death occurred, on the date stated above, at 4:32 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis & Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home of decd

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Abm B Seeman, M. D.

4/13/1922 (Address) 714 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md.

DATE OF BURIAL 4-15 1922

20 UNDERTAKER E & B Hasle

ADDRESS 115 E & West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63437

CERTIFICATE OF DEATH.

31 D 63437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3305 E Baltimore ST., 76 WARD)

2-FULL NAME Lillian J. Thompson

(a) RESIDENCE No. 3305 E Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 29 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	20	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Packer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Thompson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Emma Thompson. (Mother)
(Address) Harford Co. Md.

15 Filed APR 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922 to April 12, 1922, that I last saw her alive on April 11, 1922 and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
from history

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) ....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. V. Mosher, M. D.

, 19 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dublin Md. Harford Co.

DATE OF BURIAL 4-14 1922

20 UNDERTAKER E & B Hale

ADDRESS 110 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63438

CERTIFICATE OF DEATH.

31

D 63438

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Elliott St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F Bonn

(a) RESIDENCE. NO. 3003 Elliott St., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Bonn

6 DATE OF BIRTH (month, day, and year) Jun 26 1871

7 AGE 57 Years 2 Months 16 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) —— Ole

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Bonn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederika Kalkhof

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Herget (Address) 3003 Elliott St

15 Filed APR 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922 to April 12, 1922 that I last saw h[illegible] alive on April 11, 1922 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Tubercular Laryngitis
+ Phthisis Pulmonalis

(duration) ... yrs. 8 mos. ... ds.

CONTRIBUTORY (Secondary) ——— (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? — unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M J McAvoy, M. D.

19 (Address) 839 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Churchville Harford County	April 16 1922
20 UNDERTAKER	ADDRESS
Louis Heumann	328 Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63439

CERTIFICATE OF DEATH.

113 D 63439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Mc Mechen ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph G. Bauereis

(a) RESIDENCE. No. 210 Mc Mechen. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Bauereis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Maria Schlag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Louis Bauereis
(Address) 210 Mc Mechen St.

15 Filed APR 14 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5 1922 to April 13 1922
that I last saw him alive on April 13 1922
and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Time of Enteritis

(Signed) Walter C Bacon, M. D.

4/13 1922 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 14. 1922

20 UNDERTAKER Mrs Mrs John H. Deufel & Son ADDRESS 801 W Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last illness should be stated.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63440 CERTIFICATE OF DEATH. 161-001 D 63440

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 W. Conway St. 6th Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE. No. 433 W. Conway St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 9th 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Clinton Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md,

12 MAIDEN NAME OF MOTHER Georgia Brannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va,

14 Informant (Address) Georgia Brown 433 W. Conway

15 Filed APR 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 9th, 19 22, to Apr 10th, 19 22, that I last saw h[illegible] alive on Apr 10, 19 22 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Asthenia
Premature birth
(6 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D Hanner, M. D.

4/10, 1922 (Address) 1 Fort. Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER [illegible]

ADDRESS APR 13 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63441

3/ D 63441

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.. 6 WARD)

2-FULL NAME Willie Garden

(a) RESIDENCE. No. 13 Ford's Court ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Bob Wm. Garden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records UNIVERSITY OF MARYLAND

(Address) M.T.H.

15 Filed APR 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

28

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to April 16 1922, that I last saw him alive on April 10 1922, and that death occurred, on the date stated above, at 1.30a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) Frances L. Dadaplaces M. D.

4-10-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 13 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63442

31 D 63442

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph (John Henry) Turner

(a) RESIDENCE. No. 2607 Boone st. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5n If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed APR 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1922, to April 10, 1922, that I last saw him alive on April 10, 1922, and that death occurred, on the date stated above, at 2.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fistula in Ano

(duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Padaglucca M. D.

4-10-22 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Health Commissioner

ADDRESS APR 13 19

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63443

CERTIFICATE OF DEATH.

D 63443

169

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Jones Falls. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gisto Velorucca

(Residence in Baltimore: No. 315 A Aliceanole St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	Single

6-DATE OF BIRTH, —

(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
45 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER, (State or Country), —

12-MAIDEN NAME OF MOTHER, —

13-BIRTHPLACE OF MOTHER, (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Informant, Saml Madoon.

(Address) 131 E Aliceanole

15- APR 14 1922 ROBERT R. KRAUTER,

Filed 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 9 — 22

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning -

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner.)

192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

DATE OF BURIAL, 19

20-UNDERTAKER, Commissioner of Health,

Per Wm. S. Wo[illegible]

ADDRESS APR 1 1922

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Augusta. Dorcas - 233-S Central Ave.
B C F. 100 Check 4117-

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Smith

D 63444 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓-001

CERTIFICATE OF DEATH. 191 D 63444

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 723 W. Lexington St. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Smith

(Residence in Baltimore: No. 723 W. Lexington St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know (Month) 1 (Day) (Year)

7-AGE, 57 about yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Laborer (b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, ( )

11-BIRTHPLACE OF FATHER (State or Country), ( )

12-MAIDEN NAME OF MOTHER ( )

13-BIRTHPLACE OF MOTHER (State or Country), ( )

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dont

(Address)

15- Filed APR 14 1922 ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhelation of Illuminating Gas

(Duration) yrs. a few hrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Accidental

(Duration) yrs. mos. ds.

(Signed) H K Fowler M. D. (Coroner.)

4-13, 1922 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

DATE OF BURIAL, , 19

20-UNDERTAKER (Commissioner of Health)

ADDRESS APR 1 1922

N.B.—Every item of information should be carefully supplied. AGE should be filled EXACTLY. PROFESSION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63445

CERTIFICATE OF DEATH.

D 63445

46

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME MARY VIRGINIA KLESSELL

(Residence in Baltimore: No. 7-E-Henrietta-St. (23 Ward) St.; 76 yrs. 3 mos. 7 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, January (Month) 6 (Day), 1846. (Year)

7-AGE, 76 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore, Maryland.

PARENTS.

10-NAME OF FATHER, Hugh S. Orem

11-BIRTHPLACE OF FATHER (State or Country), Talbot Co., Md.

12-MAIDEN NAME OF MOTHER Elizabeth H. Collins

13-BIRTHPLACE OF MOTHER (State or Country), Talbot Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Chas. J. J. Carroll (Nephew)

(Address) 4012-Brookline Av., City.

15-

Filed APR 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 13 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to April 13 1922, that I saw her alive on April 13, 1922, and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix

of Uterus (Duration) ....yrs. ....mos. ....ds.

(Signed) Herman T. Dorf M. D.

4/13..., 1922 (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs. 11 mos. 13 ds. In the State 76 yrs. 3 mos. 7 ds.

Where was disease contracted, if not at place of death? ? ? ? ? ?

Former or usual residence 7-E-Henrietta St., City.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Apr-15-22, 191...
20-UNDERTAKER STEWART & BOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63446

CERTIFICATE OF DEATH.

99 D 63446

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Calverton Road WARD)

2-FULL NAME Elizabeth M. Kirsch

(a) RESIDENCE. No. 1191 S. Calverton Road WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 17-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Kirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Martha Goette

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charles Kirsch (Address) 1198. Calverton Road

15 Filed APR 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 12, 1922, that I last saw h— alive on April 12, 1922, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis & debilitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Robinson, M. D.

, 19 (Address) 212 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Apr. 15 1922

20 UNDERTAKER George L. Lohmeyer ADDRESS 710 Eutaw Ave.

D 63447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

96 D 63447

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 850 W. Lombard ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Jones

(Residence in Baltimore: No. 850 W. Lombard St.: 15. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widower

6-DATE OF BIRTH, Sept (Month) 24 (Day), 1847 (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: State worker
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country), Wales

PARENTS.

10-NAME OF FATHER, Wm. J. Jones

11-BIRTHPLACE OF FATHER (State or Country), Wales

12-MAIDEN NAME OF MOTHER Eliz Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. B. Jones

(Address) 850 W. Lombard st

15- Filed APR 14 1922, 191... ROBERT A. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) don't know mos. ds.

CONTRIBUTORY (Secondary) don't know

(Duration) yrs. mos. ds.

(Signed) W. H. Greene, M. D. (Coroner.)

4-14, 1922 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 4-15, 1922

20-UNDERTAKER Geo. J. Smith

ADDRESS 1000 W. Fayette St.

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63448

HEALTH DEPARTMENT—CITY OF BALTIMORE

J 003
D 63448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at — Registered No. C.....

City of BALTIMORE: (No. St Agnes Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kuhl

(Residence in Baltimore: No. 2003 Eagle St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Mar (Month) 2 (Day) 1901 (Year)

7-AGE: 21 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Albert Kuhl

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Sadie Staab

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Kuhl

(Address) 2003 Eagle St.

15- Filed APR 14 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) autopsy find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration of both Lungs
Rupture Liver & Spleen
Auto accident
(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage
(Duration) Sudden yrs. mos. ds.

(Signed) James McFeeley (Coroner.) M. D.

4/13/ 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Frederick Road

Former or usual residence 2003 Eagle St.

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Apr. 14, 1922

20-UNDERTAKER, Harry H. Weitzel — ADDRESS 1531 W. Lombard

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63449

PLACE OF DEATH

CERTIFICATE OF DEATH

100-001 D 63449

REGISTERED NO. C

CITY OF BALTIMORE (No. 1132 S. Charles ST. 23 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Roemer Clark

(Residence in Baltimore: No. 1132 S. Charles St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Mar 26, 1921 (Month) (Day) (Year)

7-AGE: 1 yrs. mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: Edward D Clark

11-BIRTHPLACE OF FATHER (State or country): New Jersey

12-MAIDEN NAME OF MOTHER: Emma Viola Evans

13-BIRTHPLACE OF MOTHER (State or country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward D Clark

(Address) 1132 S. Charles St

15 Filed APR 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 14, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 12. 1922. to April 14 1922. that I saw him alive on April 14 1922. and that death occurred, on the date stated above, at 6.30 a 11 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. ? ds

Contributory (SECONDARY) abscess infection,

(Duration) yrs. mos. ds.

(Signed) C. Denny M. D.

4/21/14 1922 (Address) 1215 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: April 15 1922

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63450

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD) 15

2-FULL NAME Baby Levin

(a) RESIDENCE No. 3403 Carlisle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1922.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Morris B. Levin

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Gregory

13 BIRTHPLACE OF MOTHER (city or town) Pittsburg
(State or country) Pa

14 Informant Dr. Morris B. Levin
(Address) 3403 Carlisle Ave

15 APR 14 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to April 13, 1922,

that I last saw her alive on April 13, 1922,

and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Stanley W. Mauhen M. D.

, 19 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 4-13 1922

20 UNDERTAKER Jack Lewis, 1439 E. Balto

ADDRESS

IMPORTANT—Should be clearly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

154667 D 63451 (63451)

HEALTH DEPARTMENT—CITY OF BALTIMORE

1634571

CERTIFICATE OF DEATH.

K 60-00 D 63451

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Fullen.

(a) RESIDENCE NO. Ronceverte, W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE: Years 16 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ronceverte. W. Va.

PARENTS

10 NAME OF FATHER: H. B. Fullen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unk

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed [illegible], 19 Registrar

15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from March 28. 1922. to April 14 1922. that I last saw her alive on April 14 1922, and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia + bronchs

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Endocarditis; myocarditis, Encephalitis for 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 4, 1922

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

(Signed) Warfield M. Firor, M. D.

4/14. 1922 (Address) Johns Hopkins Hosp. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ronceverte. W. Va

DATE OF BURIAL: April 14 1922

20 UNDERTAKER: Joseph Ahern

ADDRESS: 221 N Eutaw

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63452

63452
D 63452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63452

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 W Fayette ST.: 18 WARD)

2-FULL NAME Edna Agusta Scott.

(a) RESIDENCE. NO. 939 W Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 11 mos. 30 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward W. Scott

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	11	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER David F. Derr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rose Vekenman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Edward W. Scott
(Address) 939 W. Fayette st

15 Filed 1922 Robert P. Harriman, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13- 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/11 1922, to 4-13- 1922, that I last saw her alive on 4-13- 1922, and that death occurred, on the date stated above, at 1140a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia,

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hayland Grain, M. D.

, 19 (Address) 1009 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apr. 17 1922
20 UNDERTAKER George J. Smith	ADDRESS 1009 W. Fayette St.

MARTIN SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15 1922

Spec.—8-24-14—M. & T.—2000 Bks.

63453 D 63453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

63453 D 63453

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 632 N. Gilmor ST.; 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis X. Ganter.

(Residence in Baltimore: No. 632 N. Gilmor St.; 52 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married.

6-DATE OF BIRTH, ... Dec. (Month) 25 (Day), 1849 (Year)

7-AGE.	If LESS than 1 day,
72 yrs. 3 mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Manufacturer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

9-BIRTHPLACE. (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Peter Ganter.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Albertina

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. W. Ganter

(Address) 4218 Cumberland Ave.

15-

Filed Robert P. Harrison, 191.....

Registrar.

APR 15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April (Month) 14 (Day), 1922 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Mch 9 1922, to Apr 14 1922, that I saw him alive on Apr 14 1922, and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 15 yrs. ....mos. ....ds.

(Signed) M Bowmanstoon M. D.

April 14, 1922 (Address) 632 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, April 17, 1922

20-UNDERTAKER George J. Smith

ADDRESS 1000 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

63454 HEALTH DEPARTMENT—CITY OF BALTIMORE 63454

D 63454 CERTIFICATE OF DEATH. 33 D 63454

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Beaumont Mathews

(a) RESIDENCE NO. 2911 Allendale Road ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ella Francis Mathews

6 DATE OF BIRTH (month, day, and year) Aug 31. 1883.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38	7	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 004

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer B & O. Railroad

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland.

PARENTS

10 NAME OF FATHER William H Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Harriet Beaumont

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Carl Grayson (Address) .....

15 Robert P. Harrison, Registrar .19.....

Burial Permit Clerk.

PR 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2. 1921, to April 14, 1922, that I last saw him alive on April 14, 1922, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Multiple Tubercular ulcers of Intestines.

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Failure.

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? 2911 Allendale Road

Did an operation precede death? Yes Date of Dec 2. 1921 April. 11. 1922.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Metcalf, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Apr. 17 1922

20 UNDERTAKER George J. Smith — ADDRESS 1000 25 Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dec. 1, 1926

[redacted] Resection of Peritoneum
Tuberculous ulcer of Intestine

April 11, 1927.

Resection of 2 feet of small intestine.

J. Gerrish

Spec.—8-24-14—M. & T.—2000 Bks.

D 63455 5
63455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 001
D 63456
63455

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 N. West ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Preston Jones

(Residence in Baltimore: No. 533 N. West St.; ..... yrs., 2 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): S

6-DATE OF BIRTH, January 16, 1912
(Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ....
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Jones

11-BIRTHPLACE OF FATHER (State or Country), Spain or Cuba

12-MAIDEN NAME OF MOTHER Williams

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Smith

(Address) 138 Washington Blvd

15- Robert P. Harrison,

Filed....., 191.....

Registrar.

Burial Permit Clerk.

R 15 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 12 1922, to April 12 1922, that I saw h[illegible] alive on April 12 1922, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Ella Smith Worthington M. D.

4/13, 1922 (Address) 138 Wash Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence 533 N. West St.

19-PLACE OF BURIAL OR REMOVAL, Westminster Md. DATE OF BURIAL, April 15, 1922

20-UNDERTAKER D. S. Downing Sons ADDRESS 1054 W. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63456 6 / 10 D 63456

CERTIFICATE OF DEATH.

63456

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 Mc Elderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loraine M. Simpson

(a) RESIDENCE. No. 2025 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm H Simpson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna M Schnader

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Wm H Simpson
(Address) 1824 N. Broadway

15 Filed APR 15 1922, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to April 14, 1922,
that I last saw her alive on April 14, 1922,
and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) William J. Rosanek M. D.

April 19 22 (Address) 801 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 15th 1922
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63457

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63457

CERTIFICATE OF DEATH.

101-04

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 123 Welcome St. 22 WARD)

2-FULL NAME Fannie Harris

(a) RESIDENCE. No. 123 Welcome St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Levin Harris

6 DATE OF BIRTH (month, day, and year) Mar. 29, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	0	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 641

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Virginia

PARENTS

10 NAME OF FATHER George Ewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Virginia

12 MAIDEN NAME OF MOTHER Fannie ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co. Virginia

14 Informant Sarah Harris

(Address) 1628 W. mulberry St.

15 Filed Robert P. Harrison, Registrar

MAY 15 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1922

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1922, to April 14, 1922, that I last saw h.. alive on April 13, 1922, and that death occurred, on the date stated above, at 4.25a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonea

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Levin Franklin M. D.

4/14, 1922 (Address) 122 W See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Apr 17 1922

20 UNDERTAKER John H. Toadvine

ADDRESS 1942 Wilkens Ave

Make sure all items are carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63458

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 20.63458

CITY OF BALTIMORE (No. 1225 Brentwood St.; 25 Ward)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Baby Lane

(Residence in Baltimore: No. 1225 Brentwood St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April 10, 1912 (Month) (Day) (Year)

7 AGE: — yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo R Lane

11 BIRTHPLACE OF FATHER (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Alma Mueller

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo R Lane

(Address) 1225 Brentwood

15 [illegible] 191

Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 10, 1912 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1912 to April 10 1912

that I saw h[illegible] alive on April 10, 1912

and that death occurred, on the date stated above, at 9-30 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. 7 mos. ds

Contributory (SECONDARY) same

(Duration) yrs. 7 mos. ds.

(Signed) Geo. McKinstry M. D.

April 12, 1912 (Address) Mount Vernon Co

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: April 12, 1912

20 UNDERTAKER: William Cook — ADDRESS: 502 E Mount Ave

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63459

CERTIFICATE OF DEATH.

D 63459

REGISTERED NO. 49

1-PLACE OF DEATH: Homewood Hosp.

CITY OF BALTIMORE: (No.) 2724 Charles St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Winfred Cook

(a) RESIDENCE. NO. 1630 John ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred: 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 26 1856

7 AGE: Years 65 | Months 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Franum Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Steiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. G. Adams 1630 John Street

15 Filed APR 15 1922, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922 to April 14, 1922 that I last saw h alive on June 14, 1922 and that death occurred, on the date stated above, at 2.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1630 John St

Did an operation precede death? No Date of 4/13/22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Lee Fellows M. D.

, 19 (Address) 2724 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters	April 17 1922
20 UNDERTAKER: William Cook	ADDRESS: 5026 Nall

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 63460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63460

CERTIFICATE OF DEATH.

13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 Whitridge Ave WARD 12)

2-FULL NAME George A Hall

(a) RESIDENCE NO. 314 Whitridge Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Hall

6 DATE OF BIRTH (month, day, and year) Dec. 4/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	64	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md

PARENTS

10 NAME OF FATHER Washington Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md

12 MAIDEN NAME OF MOTHER Rhoda Kellum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md

14 Informant Josephine Hall

(Address) 314 Whitridge Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to Apl 13, 1922.

that I last saw him alive on April 13, 1922,

and that death occurred, on the date stated above, at 7.05 a. m.

The CAUSE OF DEATH* was as follows:

Septic Bulbar Paralysis

(duration) yrs. 1 mos 13 ds.

CONTRIBUTORY (Secondary) Paralysis respiration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms.

(Signed) Hugh Forsythe, M. D.

19 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn buy Apl 19 22

DATE OF BURIAL

UNDERTAKER William Cat

ADDRESS 502 E Nutter

MEDICAL EXAMINER

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 15 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63461

CERTIFICATE OF DEATH.

D 63461

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2557 W. Fairmount Ave ST., WARD)

2-FULL NAME Geraldine F. Duval

(a) RESIDENCE NO. 2557 W. Fairmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16" 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Compton I. Duval

11 BIRTHPLACE OF FATHER (city or town)
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mamie Mc Cain

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pa.

14 Informant Compton I. Duval
(Address) 2557 W. Fairmount Ave.

15 Apr 14 1922, 19 Robert T. Barrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14" 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to April 14, 1922,

that I last saw h alive on April 14, 1922,

and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj O Wilson, M. D.

Apr. 14, 1922 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	April 15" 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Dallas St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 15 1922 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 63462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63462

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2729 Hudson ST.; 1 WARD)

2-FULL NAME John P. Glock

(a) RESIDENCE. NO. 2729 Hudson ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced—
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 14-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Glocks

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Marie Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant John Glock (Address) 2729 Hudson St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1922

17 I HEREBY CERTIFY, That I attended deceased from 28 Mar, 1922, to 13 Apl, 1922, that I last saw h[illegible] alive on 13 Apl, 1922, and that death occurred, on the date stated above, at 4 40 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles 17 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

, 19 (Address) 3015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Swartz Cem	April 15 192
20 UNDERTAKER	ADDRESS
Stephen J. Galbraith	[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

155003.
D 63463.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63463

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvin Barmack. ~~St. City~~

(a) RESIDENCE NO. 1404 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ Benjamin Barmack (Father)

6 DATE OF BIRTH (month, day, and year) Aug 16, 1914

7 AGE: Years 6 Months 7 Days 29. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Benjamin Barmack.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia.

12 MAIDEN NAME OF MOTHER Frieda Weinstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 APR 15 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to April 14, 1922, that I last saw him alive on April 14, 1922, and that death occurred, on the date stated above, at 6 55 P. m.

The CAUSE OF DEATH* was as follows:

Pericarditis

(duration) ... yrs. ... mos 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? 1404 E Baltimore St

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Oscar B Mason, M. D.

Apr 14, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 4/16 1922

20 UNDERTAKER: Jack Lewis 1439 E Balto St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly broncho pneumonia. No infection prior.

Sarah Hughes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63464

CERTIFICATE OF DEATH.

101-001

D 63464

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Hughes

(Residence in Baltimore: No. 102 Thursby Court St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Col	Widow

6-DATE OF BIRTH, ... (Month) — (Day) 1 (Year)

7-AGE. 48 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: A work 070
(b) General nature of industry, business, or establishment in which employed (or employer): House Work

9-BIRTHPLACE. (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER, Chas. Hughes

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Martha Adkins

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Hughes

(Address) 102 Thursby St

15- Robert F. Harrison,

APR 13 1922 191..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Fourdays (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) M. J. Riley M. D.
(Coroner.)

April 15, 1922 (Address) 639 Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	April 15, 1922
20-UNDERTAKER Mrs Robert F Elliott	ADDRESS 1725 Ashland Av

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63465

CERTIFICATE OF DEATH.

REGISTERED NO. 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Gough ST., 76 WARD)

2-FULL NAME Mary Elizabeth Hurd

(a) RESIDENCE No. 3508 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur H. Hurd

6 DATE OF BIRTH (month, day, and year): May 12-1856

7 AGE: Years 65 Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): Off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Wm Brownbridge

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Alfred Hurd 3508 Gough St

15 Robert J. Carlson, Registrar

APR 15 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 27, 19 22 to April 12, 19 22, that I last saw h[illegible] alive on April 12 19 22, and that death occurred, on the date stated above, at 4 45 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. E. Young M. D.

April 13. 1922 (Address) 1107 Eutaw Pl Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: April 15 1922

20 UNDERTAKER: J Herring & Co

ADDRESS: 2008 Eutaw

MAYOR should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 S.Broadway ST. 3 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Magdeline Gill

(a) RESIDENCE. No. 8 S.Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of William R.Gill

6 DATE OF BIRTH (month, day, and year) Oct. .1836 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	85	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Manson

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Etchberger

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Miss Mamie Gatchair
(Address) 8 S.Broadway

15 Filed [illegible] 19 [illegible] W. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl.14.1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 13 , 1922 , to Apr. 14 , 1922 ,
that I last saw h[illegible] alive on Apr. 13 , 1922 ,
and that death occurred, on the date stated above, at 2;31 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms & history

(Signed) A. F. Ries, M. D.

Apl 14 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	4-17-22 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

MAKE ENTRIES IN INK. Answers should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 1 5 1922

Spec.—1-10-21—M&T—1500 Bks.

15-4944 D 63467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63467

31

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " " ST., 12 WARD)

2-FULL NAME Mary Thompson

(a) RESIDENCE NO. 1546 W. Cary St. City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND OF~~ ~~OR WIFE OF~~ of Viola Thompson (mother)

6 DATE OF BIRTH (month, day, and year) Oct.? - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) .....

12 MAIDEN NAME OF MOTHER Viola Thompson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) .....

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to April 14, 1922, that I last saw her alive on April 14, 1922, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Horace G. Stewart, M. D.

4/15, 19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cem

DATE OF BURIAL April 17 1922

20 UNDERTAKER Daniel Easton

ADDRESS Pa ave

APR 15 1922 ROBERT F. HARTMAN, Registrar of Vital Statistics.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63468

CERTIFICATE OF DEATH.

D 63468

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N. Bruce Street ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Birdie Hall

(a) RESIDENCE NO. 513 N. Bruce Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hall

6 DATE OF BIRTH (month, day, and year) Feb. 7th. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	32	4	5	

8 OCCUPATION OF DECEASED Laundress 041

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Took in washing

(c) Name of employer Herself

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Mose Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Lavinia Arthur

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co. Md.

14 Informant John Hall
(Address) 513 N. Bruce St.

15 Filed , 19 Robert F. Harrison, Registrar

APR 15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12-'22 19

17

I HEREBY CERTIFY, That I attended deceased from April 9th. 19 22 to April 12th 19 22. 19 .

that I last saw her alive on April 12th. 1922 19 ,

and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Brooken Compensation (cardiac)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Aortic Ins.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson Walter J. Jackson M. D.

, 19 (Address) 1918 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL April 15 1922

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63469 001 74 D 63469

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 217 W. Hoffman ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara E. Garrett

(Residence in Baltimore: No. 217 W. Hoffman St. St.; yrs. 75 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, ... March (Month) ..... (Day) 1843 (Year)

7-AGE, 79 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE. (State or Country): Va

PARENTS.

10-NAME OF FATHER: [illegible] Kemp

11-BIRTHPLACE OF FATHER (State or Country): Kent

12-MAIDEN NAME OF MOTHER: [illegible]

13-BIRTHPLACE OF MOTHER (State or Country): Kent

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Jones

(Address) 217 W. Hoffman

15- APR 15 1922 Robert P. Harrison, Burial Permit Clerk. 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said jury find that said deceased came to ... death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

April 14 1922 (Address) 2102 Edgewood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, April 16, 1922

20-UNDERTAKER Daniel Easton — ADDRESS 916 E Fair

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63470

CERTIFICATE OF DEATH.

D 63470

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 911 N. CASTLE STREET (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ALOIS PAZDERA

(a) RESIDENCE. (No.) 911 N. CASTLE STREET (St.) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharina Pazdera

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work TAILOR 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BOHEMIA

PARENTS

10 NAME OF FATHER FRANK PAZDERA

11 BIRTHPLACE OF FATHER (city or town) (State or country) BOHEMIA

12 MAIDEN NAME OF MOTHER ALOISE SVOBODA

13 BIRTHPLACE OF MOTHER (city or town) (State or country) BOHEMIA

14 Informant Catherine Pazdera

(Address) 911 N Castle St

15 Filed ....., 19.... Registrar

Robert P. Harrison,

Burial Permit Clerk.

APR 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1922, to April 14, 1922, that I last saw him alive on April 14, 1922, and that death occurred, on the date stated above, at home 8 A m.

The CAUSE OF DEATH* was as follows:

CARCINOMA of SCROTUM

(duration) ....yrs. 9 mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of about Nov.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) William J. Sauer, M. D.

, 19 (Address) 801 N. KENWOOD AVE.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill

DATE OF BURIAL April 16 1922

20 UNDERTAKER Hart Erickson

ADDRESS 1906 Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63471 D 63471

HEALTH DEPARTMENT—CITY OF BALTIMORE

63471 D 63471

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. South Baltimore Gen. Hospital ST.; WARD)

2-FULL NAME George Davis

(a) RESIDENCE. NO. 1523 Covington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18th 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md.

PARENTS

10 NAME OF FATHER R. Lester Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md.

12 MAIDEN NAME OF MOTHER Florence Kirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) R. Lester Davis 1523 Covington St.

15 Filed APR 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1922, to April 13, 1922, that I last saw him alive on April 13, 1922, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

acute gangrenous appendicitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes partial 4/13/22

What test confirmed diagnosis?

(Signed) Joseph Pokorny, M. D.

, 19 (Address) South Balto. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Apr 16 1922
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1460 Battery Av

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

63472 D 63472

HEALTH DEPARTMENT—CITY OF BALTIMORE

63472

CERTIFICATE OF DEATH.

90 D 63472

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Gilmore St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbert Chamberlain

(a) RESIDENCE No. 405 N. Gilmor St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Wiowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Chamberlain

6 DATE OF BIRTH (month, day, and year) Marrch 20th. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
R	40	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer, Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Middlesex Co. Va.

PARENTS

10 NAME OF FATHER Walter Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Co. Va.

12 MAIDEN NAME OF MOTHER Pauline Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) King and Queen Co. Va.

14 Informant Edith Evans

(Address) 1816 Mervine St. Phila. Pa.

15 Filed APR 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14/'22 19

17

I HEREBY CERTIFY, That I attended deceased from April 4th. 19 22 to April 14th 19 22

that I last saw h im alive on 4/14th. 1922 19

and that death occurred, on the date stated above, at 6: P m.

The CAUSE OF DEATH* was as follows:

Brooken Compensation

(Cardiac)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J.Jackson Walter J. Jackson M. D.

19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bowler's Wharf, Va

DATE OF BURIAL April 17, 1922

20 UNDERTAKER Kate R. Williams

ADDRESS 1114 W. Saratoga St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63473 D 63473

HEALTH DEPARTMENT—CITY OF BALTIMORE,

63473 D 63473

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH The Union Memorial Hospital

CITY OF BALTIMORE: (No. ... ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Charles E. Hazelton

(a) RESIDENCE. No. The Meadow Apts Providence R. I. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bell, Caldwell 743 Broadway New York City

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Wm E Hazelton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vt.

12 MAIDEN NAME OF MOTHER Lyza Anne Lutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mrs Hazelton (Address) The Meadow Apts Providence R.I.

15 APR 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to April 15, 1922, that I last saw h. alive on April 15, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid probably of several months duration

Pelvic abscess of 4 days duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/6/22

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical Exam.

(Signed) Gordon A. Deagean, M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Providence R.I. DATE OF BURIAL April 16 1922

20 UNDERTAKER A. Jenkins & Son Co. ADDRESS Dickson & Nicholson

Entries should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63474 CERTIFICATE OF DEATH. 90 D 63474

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #849-Hamilton-Terrace ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY ELEANOR JONES

(a) RESIDENCE. No. 849-Hamilton-Terrace ST., 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? 77 yrs. 5 mos. 14 ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) October-31-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Levin Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co Maryland

12 MAIDEN NAME OF MOTHER: Zeannette Bohen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester Co Maryland.

14 Informant: Mrs Carrie Jones Denmead (sister)
(Address) Towson, Maryland.

15 Filed APR 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to April 14, 1922

that I last saw h[illegible] alive on April 12, 1922

and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frederick Mebben, M. D.

, 19 (Address) Frederick Mebben 1609 Hunter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Apr-17-22

20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (CHARLES E. MOWEN, Successor)	106 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63475 CERTIFICATE OF DEATH. 231 D 63475

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2021 W. Lanvale ST.: 16 WARD)

2-FULL NAME Francis August Whittington

(a) RESIDENCE. No. 2021-W-Lanvale ST. 16 WARD. (Dunkirk-Calvert Co. Md.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? 31 yrs. 2 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther E. Whittington

6 DATE OF BIRTH (month, day, and year) Feby 6-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Maryland.

PARENTS

10 NAME OF FATHER John W. Catterton

11 BIRTHPLACE OF FATHER (city or town) Huntingtown (State or country) Calvert Co Md.

12 MAIDEN NAME OF MOTHER Lavan Catterton

13 BIRTHPLACE OF MOTHER (city or town) Huntington (State or country) Calvert Co Md.

14 Informant Mrs. C. Whittington (Address) Dunkirk P.O. Cal Co Md

15 APR 16 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1921, to April 15th, 1922, that I last saw h.. alive on April 15th, 1922, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 12 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Dunkirk Calvert Co Md

Did an operation precede death? No Date of .....

Was there an autopsy? No. Microscopic & Clinical findings

What test confirmed diagnosis? .....

(Signed) Bramwell Fenge, M. D.

, 19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dunkirk Smithville M.E. Cemetery-Calvert Co. Md. DATE OF BURIAL: April 17/ 1922

20 UNDERTAKER: J. [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63476

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH D 63476

City of BALTIMORE: (No. Mt. Hope Retreat St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME THOMAS HALLIGAN (About-35yrs)

(Residence in Baltimore: No. Mt. Hope Retreat (28-Ward) St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH. About--------1848
(Month) (Day) (Year)

7-AGE. About 74 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Night Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer) Mt. Hope Retreat

9-BIRTHPLACE, (State or Country). Ireland.

PARENTS.

10-NAME OF FATHER. John Halligan

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Mary Ford

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records at Mt. Hope Retreat

(Address) Baltimore, Maryland.

15- Filed APR 16 1922, 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14, 192.2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic pneumonia

(Duration) .....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) arterio-cap[illegible] - accident 4/10/22

(Duration) .....yrs.....mos.....ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

April 15 1922 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death 35 yrs. ? mos. ? ds. In the State 35 yrs. ? mos. ? ds.

Where was disease contracted, if not at place of death? near Mt. Hope Retreat.

Former or usual residence Mt. Hope Retreat

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Joseph's Cem. Texas, Md.	Apr-17-22

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Supervisor) ADDRESS 108 W. NORTH AVE.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63477

CERTIFICATE OF DEATH.

90D 63477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 W. Lafayette Av ST. 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Constance Winn

(Residence in Baltimore: No. 122 W. Lafayette Ave St.; ....yrs.,....mos.....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Sing

6-DATE OF BIRTH, June (Month) 28 (Day), 1854 (Year)

7-AGE,	If LESS than 1 day,
67 yrs. ....mos. ....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady at Home
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Winn

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary O'Donovan

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Frankster Smith

(Address) 12 E. Lexington

15- Filed APR 16 1922, 191.... ROBERT M KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 9 1922, to Apr. 14 1922, that I saw h.r alive on Apr. 14 1922, and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

Ordema Lungs (Duration) ....yrs. ....mos. 1/2 ds.

(Signed) Wm J Schmidt M. D.

Apr. 14, 1922 (Address) 701 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion U.E. Cem	4-17, 1922

20-UNDERTAKER	ADDRESS
Henry W Jenkins & Son	1101 Lydia

Received.

Spec.—1-10-21—M&T—1500 Bks.

D 63478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63478

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH Jewish Aged Home

CITY OF BALTIMORE: (No. Hebrew Aged Home ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Samalson

(a) RESIDENCE NO. 115 Aisquith Street ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 15 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. Baltimore St.

15 Filed APR 16 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1922, to April 15th, 1922, that I last saw her alive on April 14th, 1922, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob L. Wismer, M. D.

4-15, 1922 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montefiore Cem. Interment 4-16 1922

DATE OF BURIAL .....

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Bks.

Biri Panzer ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63479

CERTIFICATE OF DEATH.

57 D 63479

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2431 Eutaw pl. ST. 19 WARD)

2-FULL NAME Biri Panzer

(a) RESIDENCE NO. 2431 Eutaw pl. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Bendek Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungarian

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungarian

14 Informant Joseph Zivitz
(Address) 2431 Eutaw pl

15 APR 16 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1922, to April 15, 1922, that I last saw h[er] alive on April 15, 1922, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilation, Coma

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Symptoms

(Signed) Joseph Zivitz, M. D.

Apr 16 1922 (Address) 15 E Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL 4/16 19 22

20 UNDERTAKER A. Levinson & Bro

ADDRESS 1127 E. Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 63480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 84 D 63480

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " St., 1 WARD)

2-FULL NAME Ruth Gikos.

(a) RESIDENCE NO. 5 Edgemere Sparrows St., Point Road. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Costos Gikos. Husband

6 DATE OF BIRTH (month, day, and year): May 25, 1895.

7 AGE: Years 26 Months 10 Days 20. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10 NAME OF FATHER: William Feller.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind

12 MAIDEN NAME OF MOTHER: Anna Reep

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 APR 16 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 14, 1922, that I last saw her alive on April 14, 1922, and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Dem I mord

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H E Brady, M. D.

April 14 1922 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Evangelical Cem — DATE OF BURIAL: 4/17 1922

20 UNDERTAKER: William Fiallowa — ADDRESS: 168 Eastern Ave

Colovelos ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63481

153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ____ St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Colovelos

(a) RESIDENCE. No. 1016 E Lombard St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
29				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook - 071

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Greece
(State or country)

PARENTS

10 NAME OF FATHER Harry Colovelos -

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Williams

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant (Address) Hospital records.

15 Filed APR 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14-1922

17 I HEREBY CERTIFY, That I attended deceased from 4-11, 1922, to 4-14, 1922, that I last saw him alive on 4-14-22, 19, and that death occurred, on the date stated above, at 6 12 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis of the neck -

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-11-22

Was there an autopsy? —

What test confirmed diagnosis? Routine -

(Signed) [illegible] M. D.

4/14, 1922 Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WOODLAWN CEM.	APRIL 17 1922
20 UNDERTAKER	ADDRESS
ROBERT BROOKS SON	CALHOUN HOLLINS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

1 Streptococcic cellulitis. Cause pneumonia.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63482

CERTIFICATE OF DEATH.

44

D 63482

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Sommerset ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Braun

(a) RESIDENCE NO. 925 Sommerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Braun

6 DATE OF BIRTH (month, day, and year) Jan 7/1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Thalheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rose Thalheimer

(Address) 925 Sommerset St

15 APR 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14. 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st 22. 1922 to April 14. 1922.

that I last saw her alive on April 14. 1922

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Carcinoma ventriculi

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. J. Pabst, M. D.

, 19 (Address) 1001 Birguith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL April 17 1922

20 UNDERTAKER Frank A. Fink ADDRESS 916 N. Gay St.

Spec.—1-10-21—M&T—1500 Bks.

D 63483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 63483

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 E. 41 st ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. H. Davidson

(a) RESIDENCE NO. 719 E. 41 st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane Davidson

6 DATE OF BIRTH (month, day, and year): April 22 1848

7 AGE: Years 73 | Months 11 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker 088

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Nsme of employer: None

9 BIRTHPLACE (city or town) (State or country): Belfast Ireland

PARENTS

10 NAME OF FATHER: James Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belfast Ireland

12 MAIDEN NAME OF MOTHER: Margt. Orr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Jane Davidson 719 E. 41 st

Filed APR 1 6 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1922, to Apr 13, 1922, that I last saw h. alive on Apr 13, 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

4/15, 1922 (Address) 733 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Apr 18 1922

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 2178 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63484

CERTIFICATE OF DEATH.

100,001

D 63484

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 W. Fayette ST. 20 WARD)

2-FULL NAME Margaret Scheib

(a) RESIDENCE No. 1839 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Scheib

6 DATE OF BIRTH (month, day, and year): Nov 22 1832

7 AGE — Years: 89 — Months: 4 — Days: 23 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 100

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Conrad Mittig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Catherine Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Amelia Scheib

(Address): 1839 W. Fayette St

15 Filed: APR 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1922, to Apr 14, 1922.

that I last saw h[illegible] alive on Apr 13, 1922,

and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Infirmities of age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Brown and Hood, M. D.

Apr 15 1922 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: April 17 1922

20 UNDERTAKER: Jos Goedens Son ADDRESS: 217 S. Pac[illegible]

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63485

D 63485

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert. Sowe.

(a) RESIDENCE. NO. 5325. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Robert. Sowe.

6 DATE OF BIRTH (month, day, and year) Apr. 12 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63.	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. D.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Thomas Sowe.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary Land

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary Land

14 Informant Mina V. Sowe

(Address) 513 W. Mulberry St

15 Filed APR 16 1922 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 14 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Apr. 11. 1922. to Apr 15. 1922

that I last saw h alive on Apr. 15. 1922

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) Years mos. ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms, Signs & Labor.

(Signed) D. J. Pleasants M. D.

. 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Claiborne Md

DATE OF BURIAL 4/17 19

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-12—H. P. Co.—1000 Bks.

D 63486

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63486

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) Hotel Drumm Vernon (ST.:) Sager Ave (WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah C. Myers

(a) RESIDENCE. No. Drumm & Sager Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Myer

6 DATE OF BIRTH (month, day, and year) Oct 14-1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John Butt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Catherine Varney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Hannah Myers (Address) Hotel Drumm

15 Filed APR 16 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13- 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1922, to April 13, 1922, that I last saw h.r alive on April 14, 1922, and that death occurred, on the date stated above, at 11.30 A.m.

The CAUSE OF DEATH* was as follows:

Senility, Heart Exhaustion

Gastro Enterostomy

Uncomplicated (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of 4 13 22

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W D Wade, M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gettysburg Penna	4/17 1922
20 UNDERTAKER William Cook	ADDRESS 502 E Wood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63487

CERTIFICATE OF DEATH.

90 D 63487

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 St. Paul Place ST., H WARD)

2-FULL NAME Laura E. Hines

(a) RESIDENCE NO. 413 St. Paul Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Sept. 30-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary J. Campbell
(Address) 413 St. Paul Place

15 FILED APR 18 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22nd, 1922, to Apr. 14th, 1922, that I last saw h.. alive on Apr. 14th, 1922, and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Eugene Heaps M. D.

, 19 (Address) 803 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Berkeley Springs W. Va. DATE OF BURIAL April 19, 22

20 UNDERTAKER Zirkler & Zirkler ADDRESS 739 Eager st

Spec.—1-10-21—M&T—1500 Bks.

63488

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-D 63488

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3100 Elliott ST., 1 WARD)

2-FULL NAME Christian J. Weber.

(a) RESIDENCE NO. 3100 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna K. Weber

6 DATE OF BIRTH (month, day, and year) April 26-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker (Retired)

(b) General nature of Industry, business, or establishment in which employed (or employer) 803

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John P. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Anna K. Weber. (Address) 3100 Elliott St.

15 Filed APR 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1922, to April 14, 1922, that I last saw h alive on April 14, 1922, and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) asthma

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. J. Mosher M. D.

, 19 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Pauls Ger Evan Luth. Cemty

DATE OF BURIAL April 17 1922

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63489

CERTIFICATE OF DEATH.

57 D 63489

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Milton ave ST., 6 WARD)

2-FULL NAME James A. Sparklin

(a) RESIDENCE No. 407 N. Milton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Sparklin

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	48	5	15	

8 OCCUPATION OF DECEASED Clerk

(a) Trade, profession or particular kind of work storeroom

(b) General nature of industry, business, or establishment in which employed (or employer) Sparrows Point

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm. F. Sparklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances M. Wilkens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Margaret Sparklin (Address) 407 N. Milton

15 Filed APR 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1922 to April 15, 1922, that I last saw him alive on April 15, 1922 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Legum M. D.

4/15 1922 (Address) 2600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 18, 1922
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63490

CERTIFICATE OF DEATH.

44 D 63490

REGISTERED NO. C.....

D 63490

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Bradley

(Residence in Baltimore: No. 508 N. Bruce St.; 12 yrs., \ mos., \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, not known (Month) (Day) 1877. (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Domestic (b) General nature of industry, business, or establishment in which employed (or employer) 03

PARENTS.

9-BIRTHPLACE, (State or Country), Md —

10-NAME OF FATHER, Sampson Powell.

11-BIRTHPLACE OF FATHER (State or Country). Md —

12-MAIDEN NAME OF MOTHER Margaret Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elva L. Young

(Address) 508 N Bruce St

15- Filed APR 16 1922, 191.... ROBERT A. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 13th (Month) (Day) 1922. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 4th 1922, to Apr 13 1922, that I saw h er alive on Apr 13th 1922, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. not known mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Harvey F. Brown M. D.

Apr 13, 1922 (Address) 1501 Presstman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Apr 16, 1922

20-UNDERTAKER James D. Davis ADDRESS 1313 Greenmount

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If LESS than 1 day, hours or minutes should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 63491

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 63491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 69 Belleview ave. Rasp Lane ST., 7 WARD)

2-FULL NAME Annie L. Lynch

(a) RESIDENCE NO. 69 Belleview ave. Rasp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of Certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm L. Lynch

6 DATE OF BIRTH (month, day, and year): Feb. 2nd 1862

7 AGE — Years: 60 — Months: 2 — Days: 12 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Samuel Stever

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Ann Broome

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland.

14 Informant: Wm L. Lynch

(Address): 69 Belleview ave.

15 Filed APR 16 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from March 23 1922 to April 14 1922

that I last saw her alive on April 14 1922

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) O. D. Neer M. D.

4/13/22 (Address) 408 S Pat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: April 18 1922

20 UNDERTAKER: Frank Lane Sons — ADDRESS: Fullerton

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63492

D 63492

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Washington Blvd ST. 21 WARD)

2-FULL NAME Lucille Marie Gamer

(a) RESIDENCE. NO. 1101 Washington Blvd ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 16-1921

7 AGE: Years — Months 7 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of Industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Fitzhugh Lee Gamer
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md
12 MAIDEN NAME OF MOTHER: Anna M. Ripley
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Rose Ripley
(Address) 1101 Washington Blvd

15 APR 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 9th, 1922 to April 15th, 1922, that I last saw h alive on April 15th, 1922, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? — No —
What test confirmed diagnosis? Clinical

(Signed) Wm Hallman, M. D.
4/16, 1922 (Address) 1701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 17 1922
20 UNDERTAKER	ADDRESS
Joseph B Cole	1003 W Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer; Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63493

1-PLACE OF DEATH

REGISTERED NO. 24/29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1409 Battery ave ST.; 24 WARD)

2-FULL NAME John Quinn

(a) RESIDENCE. No. 1409 Battery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 40 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A Quinn

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) B+O
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Francis Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary E. Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Quinn
(Address) 1409 Battery Ave.

15 APR 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/22

17 I HEREBY CERTIFY, That I attended deceased from 4/7/ 1922, to 4/12/22, 19 ,
that I last saw him alive on 4/12/22, 19 ,
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Generalized arteriosclerosis
Chronic nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs + symptoms

(Signed) J. Edward Norris, M. D.

4/12, 1922 (Address) 1430 Riverside ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Apr. 17 1922
20 UNDERTAKER Margaret S. Flynn	ADDRESS 1421 Eight St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-00

D 63494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S. Bond St., 3 WARD)

2-FULL NAME Sarah Rira Pass

(a) RESIDENCE NO. 226 S Bond St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Pass

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Interment (Address): Jack Lewis Jiggy Ebalt

15 Filed APR 17 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1922

17 I HEREBY CERTIFY, That I attended deceased from 1919, to April 14, 1922, that I last saw her alive on " " 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collenberg, M. D.

Apr. 16 1922 (Address) 1810 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/17 1922

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63495

CERTIFICATE OF DEATH.

118 09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carlos A. Bosley.

(a) RESIDENCE NO. 1121 West Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lottie E. Bosley.

6 DATE OF BIRTH (month, day, and year) April 1, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver. 073

(b) General nature of industry, business, or establishment in which employed (or employer) Fred Method Laundry.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER William Bosley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elenor Hayman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Lottie E. Bosley (Address) 1121 W. Hamburg St.

15 Filed APR 17 1922 ROBERT F. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to April 13, 1922, that I last saw h~~im~~ alive on April 13, 1922, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Plastic Peritonitis

Intestinal Obstruction.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Toxemia. Cardiac Failure. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1121 West Hamburg St.

Did an operation precede death? Yes Date of April 12, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John D. Whitcraft, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Apr. 17 1922

20 UNDERTAKER Mr. & Mrs. J. W. Teufel & Son ADDRESS 201 N. Fayette St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63496

CERTIFICATE OF DEATH

74-001

D 63496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1571 N. Gallay ST., 8 WARD)

2—FULL NAME Minnie Kemp

(a) RESIDENCE No. 1571 N. Gallay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic-070

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER. (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Estella Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Louis Kemp (Address) 1571 N. Gallay St

15 Filed APR 17 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 8, 1922, to Apr 15th, 1922, that I last saw h alive on Apr 15, 1922, and that death occurred, on the date stated above, at 9:15 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy—

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) P. Gaines Cunnell, M. D.

(Address) 1334 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Samuel Arnolds

DATE OF BURIAL 4-17 1922

20 UNDERTAKER Robert E. Lee Williams

ADDRESS 1106 Oakland Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63497

CERTIFICATE OF DEATH.

90 D 63497

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 N. Luzerne Ave ST., 7 WARD)

2-FULL NAME August F. Sommers

(a) RESIDENCE NO. 522 N. Luzerne Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Sommers

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Martin Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Pepper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Kate Sommers (Address) 522 N. Luzerne Ave

15 Filed APR 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1921, to April 14, 1922, that I last saw h— alive on April 13, 1922, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Dis. - Et Senility

arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General - Anasarca

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

, 19 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL April 19 22

20 UNDERTAKER L. Sander Sons ADDRESS 1710 Pied Ave

Spec.—1-10-21—M&T—1500 Bks.

Lanham.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63498

CERTIFICATE OF DEATH.

45

D 63498

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (ST.) 19 (WARD)

2-FULL NAME Mr. Harry Lanham

(a) RESIDENCE NO. 533 W. Calhoun (WARD) LK

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hattie Lanham

6 DATE OF BIRTH (month, day, and year) July 22 1880

7 AGE: Years 41 yrs. Months 8 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 075

(b) General nature of Industry, business, or establishment in which employed (or employer) Druggist

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) Do not know (State or country)

14 Informant Mrs. Hattie Lanham

(Address) 533 W. Calhoun St

15 Filed APR 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 23, 1922 to April 15 1922

that I last saw him alive on April 15, 1922

and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid-
(Perforation-Peritonitis)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis-Intestinal Obstruction

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Operation-Autopsy

(Signed) I. M. Calvert, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: April 17 1922

20 UNDERTAKER: F. B. Wagner — ADDRESS: 2336 Frederick Ave

Spec.—1-10-21—M&T—1500 Bks.

D 63499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63499

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2429 Foster Ave. St. 1 WARD)

2-FULL NAME Elizabeth May O'Connor.

(a) RESIDENCE NO. 2429 Foster Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1. 1908

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
13	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Henry O'Connor.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Elizabeth M. Garphart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Henry O'Connor. (Address) 2429 Foster. ave.

15 Filed APR 17 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15. 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 11th, 1922, to Apr. 15. 1922, that I last saw her alive on Apr. 15. 1922, and that death occurred, on the date stated above, at 9.20 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

First taken ill with Influenza 1-13-1922 Which I have attributed as a contributing (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) D. W. Jordt, M. D.

4/17/1922 (Address) 1013 Hollewood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 4/18 1922

20 UNDERTAKER: John A. Moran — ADDRESS: 3006 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Milton Ave. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Coyne

(a) RESIDENCE NO. 8 N. Milton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

12, 30

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Coyne, deceased

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 75 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: — Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mary C. Coyne

(Address): 8 N. Milton Ave.

15 APR 17 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Apr 16, 1922.

that I last saw h[illegible] alive on Apr. 16, 1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Terminal Pneumonia

000

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B V Kelly M. D.

, 19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cemetery — DATE OF BURIAL: 4/19/22

20 UNDERTAKER: John A Moran — ADDRESS: 3000 E Lafayette

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hypostatic pneumonia

No hemorrhage

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63501

D 63502

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Mc Elderby ST., 5 WARD)

2-FULL NAME Catherine McGann

(a) RESIDENCE NO. 1735 McElderby ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew McGann

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Andrew McGann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm J. McGann

(Address) Westwood & Hamilton

15 APR 17 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17 I HEREBY CERTIFY, That I attended deceased from (April 7th, 1922, to April 15th, 1922,

that I last saw her alive on April 13th, 1922,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Senility - Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary Analysis

(Signed) L. J. McCarthy, M. D.

April 16th, 1922 (Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 4/18 1922

20 UNDERTAKER William Cook

ADDRESS 502 North

Wm Hayes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63502 — CERTIFICATE OF DEATH. — D 63502

14 — 001

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. University Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hayes

(Residence in Baltimore: No. 524 W Cross st) St.; 2 yrs., 3 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: May (Month) 10, (Day) 1857 (Year)

7-AGE: 65 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Laborer (640)

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Emeral Hays

11-BIRTHPLACE OF FATHER (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Susie Jones

13-BIRTHPLACE OF MOTHER (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Harrison

(Address) 524 W. Cross St.

15- Filed APR 17 1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit (Over)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: April (Month) 12, (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, au-) topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Conrad, M. D. (Coroner)

4-17, 1922 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Carroll — DATE OF BURIAL: April 17, 1922

20-UNDERTAKER: Mrs. George H. Hooper — ADDRESS: 406 W. Conway St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 63503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1247 Glyndon Ave ST.; 7 WARD)

2-FULL NAME Mary Kartnosky

(a) RESIDENCE. No. 1247 Glyndon Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Peter Kartnosky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS'

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Anna Kartnosky
(Address) 1247 Glyndon Ave

15 Filed APR 17 1922, 19 ROBT. P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14- 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1921, to April 14, 1922, that I last saw h[illegible] alive on April 14, 1922, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus
Bladder & Intestines

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Pathological & Clinical Evidence

(Signed) Shepherd Brain M. D.

, 19 (Address) 6227 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mathews Cemetery	Apr 17 1922
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1514 Lombard St

Margaret A. Kelley. ✓

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63504 — 18 D 001 — 63504

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp. 23 ESTAB. OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Margaret Kelley

(Residence in Baltimore: No. 1044 S Charles St St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	W.	S.

6-DATE OF BIRTH. Sept 5th ....., 1860.
(Month) (Day) (Year)

7-AGE, 61 yrs. 7 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Edw. Kelly.

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Mary Kelly

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. McHale

(Address) 1044 S Charles St

15- Filed APR 17 1922 ROBERT R. KNAUER, Burial Permit Clerk ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April 15, 1922.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from April 14 1922, to April 15 1922, that I saw h.. alive on April 15 1922, and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Obstruction

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Thrombosis Coronia (Right)

(Duration) ....yrs. ....mos. ....ds.

(Signed) M. C. Mahoney M. D.

....., 191... (Address) 1705 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Bonnie Brae

DATE OF BURIAL. April, 191.

20-UNDERTAKER J. J. Gahagan & Sons

ADDRESS 1318 Light

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Infant Deoms.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63505

CERTIFICATE OF DEATH.

161-801 D 63505

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 717 N. Rose Street (St.) (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DEOMS

(a) RESIDENCE. No. 717 N. ROSE STREET St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Deoms

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bessling

13 BIRTHPLACE OF MOTHER (city or town) Halto., Md.
(State or country)

14 Informant FRANK DEOMS
(Address)

15 Filed APR 14 1922 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to April 14, 1922, that I last saw her alive on April 14, 1922, and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:

PREMATURE BIRTH

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Reynolds, M. D.

April 14, 1922 (Address) 801 N. KENWOOD AVE.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS APR 17 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63506

D 63506 CERTIFICATE OF DEATH.

100/006 D 63506

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 Exeter St ST., 5 WARD)

2-FULL NAME Elizabeth Mays

(a) RESIDENCE NO. 523 Exeter St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE — Years: 3 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Born [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jessie Mays

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Josephine Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Jessie Mays 523 N Exeter St

15 Filed APR 17 1922 19 ROBERT R. KRAUTH, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922 to April 15, 1922

that I last saw her alive on April 15, 1922

and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

Bronchio Pneumonia (duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia (duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4-15, 1922 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] HOPKINS HOSP.

DATE OF BURIAL ... 19

20 UNDERTAKER [illegible] Commissioner Health,

ADDRESS APR 15 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63507

CERTIFICATE OF DEATH.

162 D 63507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 11 WARD)

2-FULL NAME Baby Evans

(a) RESIDENCE NO. 1216 Cullen St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11-22

7 AGE	Years	Months	Days	If LESS than 1 day 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER James Evans

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie Lucas

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Mamie Evans (Address) 1216 Cullen St

15 APR 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1922, to April 12, 1922, that I last saw h[illegible] alive on April 12, 1922, and that death occurred, on the date stated above, at 12 30 Am

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY Maternal septicemia

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Evans, M. D.

4-14-1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 15 1922

JOHNS HOPKINS HOSPITAL

Commissioner Health.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63508

CERTIFICATE OF DEATH.

161-001

D 63508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 W Lexington ST., 4 WARD)

2-FULL NAME Albert Leslie Bolmer Jr.

(a) RESIDENCE NO. 728 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 15 22

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Albert L. Bolmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Jersey

12 MAIDEN NAME OF MOTHER Grace V. Burgess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant A L. Bolmer

(Address) 728 W Lexington St

15 Filed APR 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Apr 15, 19 22 to Apr 15, 19 22.

that I last saw h[illegible] alive on Apr. 15, 19 22,

and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Prematurity & weakness

6½ Mo. Foetus

Mother ill with Fever

(duration) yrs. mos. ds.

Millet for Typhoid

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/15, 19 22 (Address) 1605 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER [illegible], Commissioner of Health.

ADDRESS

APR 15-1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63509

CERTIFICATE OF DEATH.

100-001

D 63509

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hanke

(a) RESIDENCE. No. Bay View Asylum. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) Municipal Hospital.

15 Filed APR 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10 1922

17 I HEREBY CERTIFY, That I attended deceased from February 27 1919 to April 10 1922 that I last saw him alive on April 10 1922 and that death occurred, on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

4/11/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 15 1922

150

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63510 — 179 — D 63510

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Madison Avenue ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Virginia Share

(a) RESIDENCE. NO. 1014 Madison Avenue ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	About 83	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Share

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Eliza Elmore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know

14 Informant Miss Kate McCarthy
(Address) 1014 Madison Avenue

15 Filed APR 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to April 15, 1922, that I last saw her alive on April 15, 1922, and that death occurred, on the date stated above, at 5:40 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Bronchial Pneumonia

(duration) Bronchial Pneumonia yrs. mos. ds.

CONTRIBUTORY (Secondary) High Blood Pressure + Chronic Interstitial Nephritis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Tunney M. D.

, 19 (Address) 812 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	4/17. 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63511

D 63511

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1230 N. Gross St. St., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn R. Smith,

(Residence in Baltimore: No. 519 Callender St. St.: 1 yrs., 8 mos. 19 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single.

6-DATE OF BIRTH, July 28, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Charles Smith,

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER Agnes Francis,

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Charles Smith.

(Address) 519 Callender St.

15- APR 17 1922 ROBERT N. KRAUTER,
Filed....., 191.... Registrar.
Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 10, 1922, to Apr. 16, 1922, that I saw h[er] alive on Apr. 16, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(Duration) — yrs. — mos. 1 W. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Thaddeus Jones M. D.

4/17/22, 191... (Address) 889 W. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 519 Callender St

Former or usual residence 519 Callender St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 4/18/22, 191...

20-UNDERTAKER J. J. Evans, Son ADDRESS Gilmor W

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63512

CERTIFICATE OF DEATH.

167

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 928 W Lexington ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Kraft

(Residence in Baltimore: No. 928 W Lexington St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ... (Month) Dont Know, 1 (Day) ..... (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Worker
(b) General nature of industry, business, or establishment in which employed (or employer): P&O

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Stehle

(Address) 2106 N. Pulaski

15-

APR 17 1922 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 15 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or inquiry.~~ thereon and from the evidence obtained by said ~~Inquest, autopsy or inquiry.~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating gas

(Duration) a few hrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Foreal M. D. (Coroner.)

4-16, 1922 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem — DATE OF BURIAL, Apr 17, 1922

20-UNDERTAKER Wm J Lickenbrock — ADDRESS N Y Pa

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63513

CERTIFICATE OF DEATH.

57 D 63513

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Elmhurst Road St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Gould

(Residence in Baltimore: No. Roland Park St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. May (Month) 17 (Day), 1834 (Year)

7-AGE, 87 yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Abel Meje.

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Jean Brown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Edwards M.D.

(Address) 3 Elmhurst Rd.

15- FILED APR 17 1922 191..... ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1904 1904, to Apr 16 1922, that I saw her alive on Apr 16 1922, and that death occurred, on the date stated above at 2.20 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 18 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John R. Oleemuller M. D.

Apr. 16 1922 (Address) 3524 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, April 18, 1922

20-UNDERTAKER W. J. Tedmen ADDRESS 926 North Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D-5-108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63514

CERTIFICATE OF DEATH.

31 D 63514

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. John Hopkins Hosp. ST. 3 WARD)

2-FULL NAME Barbara Arelzo

(a) RESIDENCE No. 1625 E. Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 27th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child 800
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Frank R Arelzo

11 BIRTHPLACE OF FATHER (city or town) Italy. (State or country)

12 MAIDEN NAME OF MOTHER Josephine Lupetza

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Penn.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 APR 17 1922 ROBERT N. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 9th 1922 to April 15 1922 that I last saw h alive on April 15th 1922 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Lumbar puncture

(Signed) Horace G. Stewart, M. D.

3/15, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lt Vincent — DATE OF BURIAL April 17 1922

20 UNDERTAKER Wendell Dippel & Son — ADDRESS 370 Mn

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Marshall

D 63515 HEALTH DEPARTMENT—CITY OF BALTIMORE 113 D 63515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 421 n Central ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Marshall

(Residence in Baltimore: No. 421 n Central St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Mal

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Baby

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John H Marshall

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Susie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Brown

(Address) 421 N Central ave

15- Filed APR 17 1922 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) C. Ross Jones M. D. (Coroner)

April 17, 191.. (Address) 1502 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury — DATE OF BURIAL, April 17 1922

20-UNDERTAKER John W Henderson — ADDRESS 1502 E monument st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63516

D 63516

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Pauline Kendle

(a) RESIDENCE NO. Hagerstown, Route 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Oct 10 1920

7 AGE — Years: 1 — Months: 6 — Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Preston Kendle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Stine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 17 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to April 16, 1922, that I last saw her alive on April 16, 1922, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Oesophagial Stricture - (Lye). (Burn)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pneumothorax following dilatation of stricture (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Hagerstown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bloodgood Mason, M. D.

4/16, 19 22 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md

DATE OF BURIAL: Apr. 17, 19 22

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63517.

CERTIFICATE OF DEATH.

90

D 63517.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 319 E 25th St. (St.:) 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles White Kramer

(a) RESIDENCE. (No.) 319 E 25th St (St.,) (WARD.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Victoria Kramer

6 DATE OF BIRTH (month, day, and year): March 7th 1847

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Amanda Kramer 4/18/22

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Grace Kramer 319 E. 25th St

15 Filed APR 17 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 28th, 1922, to April 15th, 1922

that I last saw h... alive on April 15th, 1922

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypocondriasis

(Duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Harry Longwell M.D. M. D.

(Address) 451 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: April 18 1922

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmount ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63518

CERTIFICATE OF DEATH.

90 D 63518

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1112 Homewood Ave. (WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alphonsus S. Sindall

(a) RESIDENCE. No. 1112 Homewood Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 1 1847

7 AGE: Years 75 Months 1 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: David Sindall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jane Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mary J. Sindall

(Address): 1112 Homewood Ave

15 Date: APR 17 1922 ROBERT R. KRAUTER, Registrar

Deputy Registrar or Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 15, 1922, that I last saw him alive on April 15, 1922, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Edema Cerebri, with Lung Complication, (Pneumonia)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Fenton, M. D.

(Address) 700 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Govans

DATE OF BURIAL: April 19, 1922

20 UNDERTAKER: H. C. Windfield

ADDRESS: 914 Fremont Ave

NOTE.—Name, residence, age, color, sex, and cause of death are required by law. PHYSICIANS: Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63519 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63519

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1101 Laurens ST., 16 WARD)

2-FULL NAME George H. C. Burman.

(a) RESIDENCE NO. 1101 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Annie Burman.

6 DATE OF BIRTH (month, day, and year) 4-12-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer. 104

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. H. Burman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise A Hetmuth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Annie Burman Wife

(Address) 1101 Laurens St

15 Filed APR 17 1922 19 J. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 23 1921 to April 15 1922

that I last saw h Wife on April 17 1922

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of Nov 23/21

Was there an autopsy? Yes

What test confirmed diagnosis? Dr Pelton

(Signed) Dr. L. Pelton M.D.

4/15 19 22 (Address) 2724 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Pk Crem

DATE OF BURIAL 4-17 19 22

ADDRESS

20 UNDERTAKER Wm. Chas A G Rohde

115 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. This information is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Richter)

D 63520 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63520

CERTIFICATE OF DEATH:

1-PLACE OF DEATH Municipal Hosp., Bay View REGISTERED NO. 100, 91

CITY OF BALTIMORE: (No. ..... St.: 16 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A. Richter

(a) RESIDENCE. No. 707 N. Payson St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Richter

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thos. F. Suzeks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Chas. F. Richter, Husband (Address) 707 N. Payson St.

15 Filed ..... 19 ..... Registrar Robert F. Sweeney, Md. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-1922

17 I HEREBY CERTIFY, That I attended deceased from 8-24-1921 to 4-15-1922 that I last saw h alive on 4-15-1922 and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Pseudo-bulbar palsy (Arteriosclerotic)

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

4-16, 1922 (Address) Municipal Hosp. Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	4/18 1922
20 UNDERTAKER	ADDRESS
Elmer St. Conklin	924 E. Eager St.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 17 1922

D 63521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63521

CERTIFICATE OF DEATH.

1887

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Geo. Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	?

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 70 + yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) none

(Address).....

15- Robert P. Harrison, Registrar.

Filed ....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobular bilateral

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bright's Disease,

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Smith Smeltz M. D.
(Coroner.)

419 ..., 1922 (Address) 4 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND. DATE OF BURIAL, ..., 19....

20-UNDERTAKER Superintendent Keefe ADDRESS

APR 17 1922

APR 17 1922

WRITE PLAINLY, WITH CARBON PENCIL OR PEN AND INK.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63522 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63522

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fabian Baker

(Residence in Baltimore: No. 575 Potomac St. Brooklyn St., yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
F.	White	Single

6-DATE OF BIRTH. Not Known (Month) (Day) (Year)

7-AGE. 75 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). "

9-BIRTHPLACE. (State or Country) Hartford Co -

PARENTS

10-NAME OF FATHER. —

11-BIRTHPLACE OF FATHER. (State or Country). —

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER. (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bay View Hospital

(Address) ...

15- UNIVERSITY OF MARYLAND.

FILED APR 7 1922 192... Robert T. J. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr. 15 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Nephritis.

(Duration) ... yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D. (Coroner.)

Apr 16 1922 192... (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 192...

20-UNDERTAKER. ADDRESS

Commissioner Health. APR 1, 1922

WRITE PLAINLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—

APR 7 1922

1915

USE MORGUE.

D 63523 HEALTH DEPARTMENT--CITY OF BALTIMORE D 63523

CERTIFICATE OF DEATH

80

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 312 Park Ave ST.: 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alberta M Newell

(Residence in Baltimore: No. 312 Park Ave St.: yrs. 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Mar 3 (Month), (Day), 1922 (Year)

7-AGE: ..... yrs. 1 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: William Newell

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Lena Devlin

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lena Devlin

(Address) 312 Park Ave

15 [illegible] Burial 1922 Permit Clerk.

REGISTRAR

APR 17 1922

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 17 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to April 17 1922, that I saw h[illegible] alive on April 16, 1922, and that death occurred, on the date stated above, at 9.20 A.M.

The CAUSE OF DEATH* was as follows:

Convulsions

0 0 0

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary D. Browne M. D.

April 17, 1922 (Address) 510 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Saint Marys Cemetery

DATE OF BURIAL: April 18, 1922

20-UNDERTAKER: Spenceriph & Son

ADDRESS: Chestnut ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cause convulsions unknown. Some intestinal disturbance but not enough to say enteritis.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted ter: for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train — accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D 63524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63524

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Washington ST., V WARD)

2-FULL NAME Mary J. Tyler

(a) RESIDENCE NO. 319 S. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Tyler

6 DATE OF BIRTH (month, day, and year) Aug 5th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cathrine W. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. F. Tyler

(Address) 319 S Washington St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 3 , 1922 , to April 14 , 1922 , that I last saw her alive on April 14 , 1922 , and that death occurred, on the date stated above, at 1 P — m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(duration) yrs. mos. 21, ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. 18, ds.

18 Where was disease contracted if not at place of death? At the place of death.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? By Examination

(Signed) Frederick L. Stoner M. D.

, 1922 (Address) 112 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 4/18 1922

20 UNDERTAKER John A Nolan 3000 E Balto St. — ADDRESS

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in stating the CAUSE OF DEATH. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Brooks)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63525

CERTIFICATE OF DEATH.

gv D 63525

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Division ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Brooks

(a) RESIDENCE No. 1734 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Brooks

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler 624

(b) General nature of industry, business, or establishment in which employed (or employer) Horses Mules

(c) Name of employer Kennedy Tomato Co. Balto. City

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER William Brooks

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Maria Burke

13 BIRTHPLACE OF MOTHER (city or town) Balto. City (State or country)

14 Informant Ethel Brooks (Address) 1734 Division St.

15 [illegible] 1922 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10 1922 to April 12 1922 that I last saw him alive on April 12 1922 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Embolism of Coronary artery

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Aleurs of Heart

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Lee Ellis M. D.

. 19 (Address) 924 Mod. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL April 18 1922

20 UNDERTAKER Daniel Foster ADDRESS 916 Pa ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK must be filled EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert P. Harrison, Registrar Health Dept. Balto.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63526

100-00

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 N. Eutaw St.: 11 WARD)

2-FULL NAME Edward—Banks—

(a) RESIDENCE. NO. 909 N. Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 11-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Easton Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ella Banks
(Address) 909 N Eutaw St

15 Filed [illegible] 19 [illegible] Registrar

APR 17 1922 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16- 1922

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1922, to April 16, 1922, that I last saw h~~im~~ alive on April 16-, 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acut Bronchitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) Samuel A Bani, M. D.

, 19 (Address) 937 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 18 1922
20 UNDERTAKER David Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be careful to have information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 63527 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63527

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2337 Eutaw Place ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Wiesenfeld

(a) RESIDENCE No. 2337 Eutaw Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanche Wiesenfeld

6 DATE OF BIRTH (month, day, and year): Dec. 29, 1857

7 AGE — Years: 64 Months: 3 Days: 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Moses Wiesenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Betzeg Freidenwald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Blanche Wiesenfeld 2337 Eutaw Pl. C

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1922

17

I HEREBY CERTIFY, That I attended deceased from March, 1921, to April 17, 1922, that I last saw h alive on April 16, 1922, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedenwald M. D.

19 (Address) 6134 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. DATE OF BURIAL: 4/18/1922

20 UNDERTAKER: David Sondheim ADDRESS: 118 W. Mt. Royal Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED OUT EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated

D 63528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63528

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. B & O Coal Pier Curtis Bay. Ward) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. Dorsey.

(Residence in Baltimore: No. 103 W. Glenmore Ave. Hamilton. St.: yrs. 41 mos. 4 ds. 14)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married

6-DATE OF BIRTH. December 1st. 1880. (Month) (Day) 1 (Year)

7-AGE. 41 yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Watchman. 062

(b) General nature of industry, business, or establishment in which employed (or employer). B & O R.R.Co.

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William Dorsey.

11-BIRTHPLACE OF FATHER, (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Margaret Harper.

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Ella E. Dorsey. (wife)

(Address). 103 W. Glenmore Ave.

15- Robert P. Harrison,

Filed ..... 192 ..... Registrar.

APR 17 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall over board.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

April 17 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Parkwood Cem.	April 18 1922
20-UNDERTAKER.	ADDRESS
Wm Cook	502 East North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63529

CERTIFICATE OF DEATH.

100-09

D 63529

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 E. North ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion J. Dick

(a) RESIDENCE NO. 1800 E. North ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David E. Dick

6 DATE OF BIRTH (month, day, and year) April 3, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	53	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Barton Allegany Co. Md

PARENTS

10 NAME OF FATHER Hugh Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant James F. Dick

(Address) 1919 E. Lafayette Ave

15 Filed Apr 18 1922 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1922, to Apr 16, 1922, that I last saw h alive on Apr 16, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

4/17 1922 (Address) 1823 N. Wash. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL April 18 1922

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1938 E. Lafayette Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 17 1922

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63530

D 63530

CERTIFICATE OF DEATH.

REGISTERED NO. 8 13

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 E North ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Loane

(a) RESIDENCE. NO. 1509 E North ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice M. Loane

6 DATE OF BIRTH (month, day, and year) June 1st 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10	15	

8 OCCUPATION OF DECEASED 886

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Custer House Inspector (Retired)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo B. Loane

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary A. Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Alice M. Loane

(Address) 1509 E North ave

15 Filed APR 17 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1915 19 .... to April 16, 1922 that I last saw h alive on Sept 19 21. and that death occurred, on the date stated above, at 5 45 a m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans (Progressive) & causing gradual loss of locomotion)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jefferies Bruce, M. D.

4/16 1922 (Address) 2 E 22 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Apr 18 19 22

20 UNDERTAKER: George J Smith — ADDRESS: 1000 Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6353 D 6353

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Chester ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Webb Gillman

(Residence in Baltimore: No. 5 Chester St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH. February 15, 1856 (Month) (Day) (Year)

7-AGE. 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 2nd Nat'l Bank

9-BIRTHPLACE, (State or Country), New York N.Y.

PARENTS.

10-NAME OF FATHER, George H. Gilman

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Harriett Webb

13-BIRTHPLACE OF MOTHER (State or Country), Scotia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Harriett A. Gilman

(Address) Calhoun & Lexington

15- Filed ....., 191.... Registrar.

APR 17 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 7 1922, to April 16 1922, that I saw him alive on April 15 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Paralysis Digestive Tract

of Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Gastritis

(Duration) yrs. mos. 10 ds.

(Signed) C. C. Hess M. D.

4/17, 1922 (Address) 2608 E. Balto.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Leem

DATE OF BURIAL, April 18, 1922

20-UNDERTAKER George J. Smith

ADDRESS 1000 W. Fayette

WRITE PLAINLY.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63532

CERTIFICATE OF DEATH.

74 D 63532

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1707 Presbury St, ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Tuemday

(Residence in Baltimore: No. 1707 Presbury St. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May, 1843
(Month) (Day) (Year)

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work,
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ~~Scott~~ John Ireland

11-BIRTHPLACE OF FATHER (State or Country), Howard C, Md

12-MAIDEN NAME OF MOTHER Lucy Shipley

13-BIRTHPLACE OF MOTHER (State or Country), Howard C, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Tuemday

(Address) 1707 Presbury St

15-

Filed ....., 191.....

Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 7 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. 1 mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

(Address) 280 W. Hamburg St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Calvary — DATE OF BURIAL, April 18, 1922

20-UNDERTAKER J. S. Marshall — ADDRESS 353 Fulton Ave

D 63533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63533

188-003

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. on way to Johns Hopkins Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Frances Hostler.

(Residence in Baltimore: No. 1914 Eastern Ave. St.; yrs., 4 mos. 9 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 27th (Day), 1917 (Year)

7-AGE, 4 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... Off

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John P. Hostler.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Minnie Bussman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John P. Hostler

(Address) 1914 Eastern ave.

15- APR 18 1922 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 15 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Int

Ag Acute (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. Krauter Jr. M. D. (Coroner)

4-18, 191.. (Address) 4 S. Howard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, April 18 1922

20-UNDERTAKER Lilly & Geiler ADDRESS 403 S. Howard St

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D 63534
REGISTERED NO.

D 63534
1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2716 Philadelphia Av ST.: 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank H. Pegg

(a) RESIDENCE. NO. 2716 Philadelphia Av ST., 6th WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Pegg

6 DATE OF BIRTH (month, day, and year) July - 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Pegg

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D.C.

12 MAIDEN NAME OF MOTHER Anna Myers

13 BIRTHPLACE OF MOTHER (city or town) Portsmouth
(State or country) Va

14 Informant Ada Pegg
(Address) 2716 Phila Ave.

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar
APR 18 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1921, to April 17, 1922, that I last saw h.. alive on April 17, 1922, and that death occurred, on the date stated above, at 6.5 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Potts disease leading to increasing deformity with embarassment of respiration & circulation for the last year. amyloid (duration) 37 yrs. mos. ds.

CONTRIBUTORY (Secondary) Degeneration of liver & kidneys
Anemia (duration) yrs. mos. 2 3/4 ds.

18 Where was disease contracted if not at place of death? ~~Phila~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank R. Smith, M. D.

, 19 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	April 18 1922

20 UNDERTAKER Jos. J. Herr ADDRESS 156 N. Luzerne Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE must be stated EXACTLY. Exact statement of (illegible) mation should be carefully supplied. AGE should be properly classified. Exact statement of (illegible) CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of (illegible) TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 63535

REGISTERED NO.

1-PLACE OF DEATH Municipal Hosp. Bay View ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO

2-FULL NAME Winifred Hosty

(a) RESIDENCE. NO. Bay View ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Eastman

6 DATE OF BIRTH (month, day, and year) Eastman

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eastman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Eastman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Hosp Records

15 Filed APR 18 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-1922

17 I HEREBY CERTIFY, That I attended deceased from 5-7-1920 to 4-16-1922, that I last saw h alive on 4-16-1922 and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Clyde Mowell, M. D.

4-17-1922 Address Municipal Hosp. Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL April 18 1922

20 UNDERTAKER Jos. J. Mew ADDRESS 156 N. Luzerne Ave.

N. B.—WRITE PLAINLY. WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 D 63536

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 E North Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susannah Burton

(Residence in Baltimore: No. 1224 E North Ave St.; ....yrs., 6 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. white

5-SINGLE, MARRIED, ~~WIDOWED~~ widowed, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, June 16 (Month) (Day), 1847 (Year)

7-AGE, 75 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General natnre of Industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country) Greenwood Balto Co Md

PARENTS.

10-NAME OF FATHER, Owen B. Burton

11-BIRTHPLACE OF FATHER (State or Country), Greenwood Balto. Co. Md

12-MAIDEN NAME OF MOTHER Eleanor Todd

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lewis T. Street
(Address) 1224 E North Ave

15- APR 18 1922 Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, apr 17 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from apr 1 1922, to apr 17 1922, that I saw h[illegible] alive on apr 15 1922, and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo M Lean M. D.

apr 17, 1922 (Address) 20 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Forest Md — DATE OF BURIAL, Apr 20 1922

20-UNDERTAKER E LeRoy Stiffler — ADDRESS 1255 North Ave

N.B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63537

CERTIFICATE OF DEATH

D 63537

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (NO. 8 Brentland Ave ST., Harford Rd WARD) 29

2-FULL NAME Martha W Galloway

(a) RESIDENCE NO. 8 Brentland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hen. E Galloway

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	64 yr	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER May Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry L Galloway (Address) 8 Brentland Ave.

15 Filed APR 18 1922 Registrar ROBERT B. KRAUTER, CHIEF REGISTRATION CLERK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1922 to Apr 15 1922

that I last saw her alive on Apr 15 1922

and that death occurred, on the date stated above, at 730 PM

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

? (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam.

(Signed) B O'Kelly, M. D.

19 (Address) 100 N. Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. — DATE OF BURIAL Apr 18 1922

20 UNDERTAKER William Cook — ADDRESS 502 E Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic parenchymatous nephritis.

Spec.-1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63538

D 63538

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Donaugh WARD 7)

2-FULL NAME Mary E Painter Mc Donaugh

(a) RESIDENCE NO. 1037 N. Donaugh ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 44 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Wm Painter

6 DATE OF BIRTH (month, day, and year): Nov 2 1895

7 AGE: Years 26 Months 5 Days ..... If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George G Beach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Vera Minnich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: George G Beach

(Address): 1037 N. Donaugh St

15 Filed ..... 19 ..... Registrar

APR 18 1922

ROBERT F. KRAUS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1 1922 to April 16 1922, that I last saw her alive on April 16 1922, and that death occurred, on the date stated above, at 4 12 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? dont Know

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) E Thomas Emrich, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem DATE OF BURIAL: April 18 1922

ADDRESS

20 UNDERTAKER: William Cadwalader

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY as near as can be ascertained. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 63539

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

101 D 63539

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 Stump Al. St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josepn Sanders. (C) 4

(Residence in Baltimore: No. 602 Stump Al. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. Age should be stated. Exact statement of occupation should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE. 26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). France.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Flossie Holmes. (C)

(Address) 602 Stump Al.

15- APR 18 1922 Filed 192 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17th. 1922. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto W. Reinhardt M. D.
(Coroner.)

April 17 1922 (Address) 10.17 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn — DATE OF BURIAL, April 18 - 1922

20-UNDERTAKER, Michael Doyle — ADDRESS, 15 E Lee St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63540

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 63540

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Miss Carter's Sanatarium 6100-Blenheim-Road. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Brinton

(a) RESIDENCE. NO. 2938-St.Paul-St. ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 87 yrs. 0 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alban Harvey Brinton

6 DATE OF BIRTH (month, day, and year): March-19-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None ooo

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Cecil Co., Maryland

PARENTS

10 NAME OF FATHER: Charles Crouch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil Co., Maryland.

12 MAIDEN NAME OF MOTHER: Mary Elizabeth May

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cecil Co., Maryland.

14 Informant: Dr. Wilmer Brinton, (son)
(Address) #1232-N-Calvert-St., City.

15 Filed APR 18 1922 ROBERT R. KRAETER, Registrar
Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th, 1922.

17 I HEREBY CERTIFY, That I attended deceased from January 10th, 1917, to April 17th 1922 that I last saw h.r alive on 5.30 p. m. April 17th 1922 and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (R. Lung) 48 hours
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Wilmer Brinton M. D.

, 19 (Address) 1232 N. Calvert Street

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GREEN MOUNT CEMETERY	Apr-19-22
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated carefully supplied. AGE should be properly classified. Exact statement of DECEASED mation should be carefully supplied, so that it may be CAUSE OF DEATH in plain terms, TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63541 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 129 D 63541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 719 S. Rose ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Haake

(a) RESIDENCE NO. 719 S. Rose ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Haake

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer Weiskittel & Son

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Haake

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Not Known

14 Informant Katie Haake
(Address) 719 S. Rose St

15 APR 18 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1922

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1922, to April 16, 1922, that I last saw h. alive on April 16, 1922, and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ... yrs. ... mos 17 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Cedar M Bliss, M. D.

April 19 22 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	April, 1922
20 UNDERTAKER	ADDRESS
D. Vanden & Son	910 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63542

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 D 63542

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2018 W Saratoga St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Robert E. Lee

(Residence in Baltimore: No. 2018 W Saratoga St.; yrs., 15 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. June (Month) 15 (Day) 1867 (Year)

7-AGE. 54 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Superintendent
(b) General nature of industry, business, or establishment in which employed (or employer)..... Tax Sale Scale

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Lee

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary McCademan

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Lee

(Address) 2018 W Saratoga

15- FILED APR 8 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide By Hanging

Duration) ..... yrs. ..... mos. Indefinite ds.

CONTRIBUTORY (Secondary) Melancholy

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) James W Fenton M. D. (Coroner)

April 17 1922 (Address) 26 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Gordon Park Cemetery DATE OF BURIAL, April 19 1922

20-UNDERTAKER, Wm. G. Black ADDRESS 1424 W. Fayette Ave

N. B.—Every item of information should be carefully supplied. Exact statement of ... may be properly classified. Exact statement of ... certificate. ... state CAUSE OF DEATH in plain terms, so that it may be ... is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1922 48

D 63543

CERTIFICATE OF DEATH.

90 D 63543

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 W Lexington St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Williams

(Residence in Baltimore: No. 1029 W Lexington St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Mar

6-DATE OF BIRTH, April 17, 1874
(Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Harriett Bland

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Williams

(Address) 1029 W Lexington

15- FILED APR 18 1922, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 1922, to April 16 1922, that I saw h..... alive on April 16 1922, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cyanide Poisoning

of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J Howard M. D.

April 17, 1922 (Address) 939 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, April 19, 1922

20-UNDERTAKER Clarence E Wright

ADDRESS 364 Mary

N.B.—Every item of information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63544

CERTIFICATE OF DEATH.

31 D 63544

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 18 Rosemont Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome C. Tucker

(Residence in Baltimore: No. 18 Rosemont ave St. 22 yrs.) mos. ds.)
Raspburg Balto ~~Md~~

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Jan (Month) 16 (Day), 1900 (Year)

7-AGE,	If LESS than 1 day,
22 yrs. 3 mos. 5 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stewart
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hotel

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER, Frank Tucker

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Anna M. Durant

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Tucker

(Address) 18 Rosemont Ave

15- APR 18 1922 191..... ROBERT R. KRAUTER, Burial Permit Clerk... Registrar.
Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14 1922, to April 16 1922, that I saw him alive on April 14 1922, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion & Coma

(Duration) ....yrs. ....mos. ....ds.

(Signed) Alf. S. Engel M. D.

4/17/22, 191.. (Address) 706 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, April 19, 1922

20-UNDERTAKER Frank Drachbar — ADDRESS 1906 Eden Street

N. B.—Every item of information should be carefully supplied. Add statements properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63545

CERTIFICATE OF DEATH.

90 D 63545

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3038 Boston ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Kudrna

(a) RESIDENCE NO. 3038 Boston St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Kudrna husband

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frank Kudrna (Address) 3038 Boston St

15 APR 18 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to Apr. 16, 1922, that I last saw h[illegible] alive on Apr 16, 1922, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan Edwards, M. D.

, 19 (Address) 308 S. Dammeron

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rodeemer DATE OF BURIAL April 19 22

20 UNDERTAKER Frank Crochon ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

D 63546

HEALTH DEPARTMENT—CITY OF BALTIMORE

1003

188 D 63546

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Balto. General Hospital. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Edward B. Aud.....

(Residence in Baltimore: No. 1520 Light St. St.; yrs. 5 mos. 2 ds. 15)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. January 31st. 1917. (Month) (Day) (Year)

7-AGE. 5 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William Aud.

11-BIRTHPLACE OF FATHER, (State or Country). St Marys Co. Md.

12-MAIDEN NAME OF MOTHER. Mary V. Ching.

13-BIRTHPLACE OF MOTHER, (State or Country). St. Marys Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Aud. (father)

(Address) 1520 Light St.

15-

Filed APR 18 1922 19.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal abdominal injuries.
Accidentally run over by an Automobile.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto W. Pinhardt M. D. (Coroner)

April 18 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Accident in front of 1520 Light St.

Former or usual residence. April 14th. 1922.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cem. C A Co	April 18 1922

20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

N. B.—Every item of information should be carefully supplied. Exact statement of cause must be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63547 (1) PLACE OF DEATH

CERTIFICATE OF DEATH

90 D 63547 REGISTERED NO. C

CITY OF BALTIMORE (No. 1126 Argyle Ave ST. 17 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J Holliday

(Residence in Baltimore: No. 1126 Argyle Ave St.; 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: November (Month), (Day), 1868 (Year)

7-AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Porter 070
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Fredericksburg Va

PARENTS

10-NAME OF FATHER: John Holliday

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Caretta Brown

13-BIRTHPLACE OF MOTHER (State or country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Holliday

(Address) 1126 Argyle Ave

15

Filed APR 18 1922

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 16 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1922 to April 16 1922 that I saw him alive on April 16 1922 and that death occurred, on the date stated above, at 12 1/2 m.

The CAUSE OF DEATH* was as follows:

Acute Insufficiency

(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY) Uric Acid in blood

(Duration) 2 yrs. mos. ds.

(Signed) J S Hawkins M. D.

April 18, 1922 (Address) 1126 Argyle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: April 18, 1922

20-UNDERTAKER: Thomas J Hemsley — ADDRESS: 5 N Bond St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63548

CERTIFICATE OF DEATH.

31 D 63548

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 E. Preston St ST.; 10 WARD)

2-FULL NAME Mary A. O'Connor

(a) RESIDENCE. No. 1209 E. Preston St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Every item should be carefully supplied. AGE should be stated EXACTLY. Every item should be carefully supplied. AGE

Spec.—1-10-21—M&T—1500 Bks.

D 63549

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 001

74 D 63549

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Ashland Ave. 10 WARD)

2-FULL NAME Mary E. Mayer

(a) RESIDENCE NO. 1228 Ashland Ave., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of DATE of birth should be carefully supplied. AGE should be stated in proper terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATE OF DEATH is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Ambrose Mayer.

6 DATE OF BIRTH (month, day, and year): Sept 21/1863

7 AGE: Years 58 | Months 6 | Days 26 | If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Emmitsburg Md.

PARENTS

10 NAME OF FATHER: A Strasbaugh.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hanover Pa.

12 MAIDEN NAME OF MOTHER: Mary H. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Emmitsburg Md

14 Informant (Address): John A Mayer. 1228 Ashland ave.

15 Filed: APR 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/14, 1922 to 4/16, 1922

that I last saw her alive on 4/16, 1922

and that death occurred, on the date stated above, at 1.15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. B. Emmart M. D.

4/16 1922 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery. DATE OF BURIAL: April 19 1922

20 UNDERTAKER: Geo. J. Ruth. ADDRESS: 1735 Hayford ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63550

CERTIFICATE OF DEATH.

91-001 D 63550

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Madison Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Alexander Fleming

(a) RESIDENCE. NO. 1018 Madison Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie S Fleming

6 DATE OF BIRTH (month, day, and year) 3/4/62

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Perkins Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth R. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Bessie S. Fleming (Address) 1018 Madison Ave

15 Filed APR 18 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17- 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 11- 1922 to April 17 1922 that I last saw h[illegible] alive on Apr 16 - 1922 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage from ruptured aneurism of aorta (transverse portion of arch)

(duration) unknown mos. ds.

CONTRIBUTORY (Secondary) none known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? X ray exam.

(Signed) Chas. J Keller M. D.

Apr 19 1922 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 19 1922
20 UNDERTAKER	ADDRESS
John B Spence	1325 N. Caroline St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63551

CERTIFICATE OF DEATH.

44 D 63551

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 12 Queen Anns Road St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R Holmwood
(Residence in Baltimore: No. 12 Queen Anns Road St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Husband of the word.) Married

6-DATE OF BIRTH, Nov 2 (Month), (Day), 1869. (Year)

7-AGE 52 yrs. 5 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Owner 086
(b) General nature of industry, business, or establishment in which employed (or employer) Restaurateur

9-BIRTHPLACE, (State or Country). Frederick Md

PARENTS.

10-NAME OF FATHER, John O Holmwood

11-BIRTHPLACE OF FATHER (State or Country) Frederick Md

12-MAIDEN NAME OF MOTHER Sara Hilter

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard H Holmwood

(Address) 12 Queen Anns Road

15-

Filed APR 18 1922 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15 (Month), (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1922, to April 15 1922, that I saw h[illegible] alive on April 15 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Gilbert D Rothermel M. D.

April 18 1922 (Address) 520 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery

DATE OF BURIAL, April 18., 1922

20-UNDERTAKER Harry H Kitzke

ADDRESS 1531 W Fayette St

N. B.—Every item of information should be carefully obtained, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Blks.

D 63552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63552

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Hillman ST., 9 WARD)

2-FULL NAME Ivan b. J. Connolly

(a) RESIDENCE NO. 1307 Hillman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 7' 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Edward J. Connolly

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. O'Connor

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr. Edward J. Connolly
(Address) 1307 Hillman St

15 [redacted] Registrar

APR 18 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922, to April 18, 1922, that I last saw h alive on April 17, 1922, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) measles preceding

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Bernard Wells, M. D.

, 19 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Apr. 19 1922

20 UNDERTAKER Henry Hoerle Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63553

CERTIFICATE OF DEATH.

31 D 63553

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Light ST.: 24 WARD)

2-FULL NAME Margaret Burgess

(a) RESIDENCE. No. 1831 Lights ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Burgess

6 DATE OF BIRTH (month, day, and year) Feb 19 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Luke McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Casey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm Burgess (Address) 1831 Light

15 Filed Apr 18 1922 Robert P. Garrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch 21 1922 to April 16 1922 that I last saw h alive on April 16 1922 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mus. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. A. Campbell M. D.

April 18 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	April 18 1922
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1417 Light St

N. B.—Name, residence, age, color, sex, and cause of death should be carefully supplied. AGE should be given in years, months, and days, and every information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63554 D 63554

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3424 O'Donnell ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Marie Pabst

(Residence in Baltimore: No. 3424 O'Donnell St.; 17 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH. July (Month) 4 (Day), 1904 (Year)

7-AGE, 17 yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Office work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Chas. F. Pabst

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Minnie M. Drommel[illegible]

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). H.N. Sisco

(Address). 1315 N. Chas. St.

15- Robert F. Harrison, Registrar.

Filed ....., 191.....

Burial Permit Clerk.

Every item of information must be given so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch. 1 1922, to Apr. 16 1922, that I saw her alive on Apr. 16 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H.N. Sisco M. D.

Apr. 17, 1922 (Address) 1315 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or [illegible]

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oakland DATE OF BURIAL. April 20, 1922

20-UNDERTAKER Fickler & Fickler ADDRESS 1739 Eager St

CH 81972

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Sieber)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63555 X10 D 63555

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.; WARD)

2-FULL NAME Jolder J. Sieber

(a) RESIDENCE. NO. Old Harford Road near Taylor Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 9, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Sieber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Lena Dove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis

14 Informant John Sieber (Address) Old Harford Road

15 Filed Robert P. Harrison, Registrar

APR 18 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 18 1922

17 I HEREBY CERTIFY, That I attended deceased from april 17, 1922 to april 18, 1922 that I last saw him alive on april 17, 1922 and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis of hip about (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes (Tracheotomy) Date of 4/17/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B MacGowan, M. D.

19 (Address) Sydenham Hospital 4/18/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL April 19 1922

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pratt

B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 63556 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63556

CERTIFICATE OF DEATH. 179

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Ridgely St Mt Lemans (ST.) 25 (WARD)

2-FULL NAME Elizabeth Herbert

(a) RESIDENCE (No.) Ridgely St Mt Lemans (ST.) ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

6a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Herbert
6 DATE OF BIRTH (month, day, and year) March 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	74	unknown		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 000
(b) General nature of Industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William Herbert
(Address) Ridgely St Mt Lemans

15 Filed ..... 19 ..... Registrar
APR 18 1922 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1922

17 I HEREBY CERTIFY, That I attended deceased from March 15 1921. 19 ..... to April 17. 19 22
that I last saw h alive on April 15 19 22
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? —

(Signed) Wesley Carlson M. D.
(Address) 1 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem
DATE OF BURIAL April 19 1922
20 UNDERTAKER John Deming & Co
ADDRESS 20-8 Eden

B. WRITE PLAINLY. AGE should be carefully supplied. Exact statement of occupation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

(Divinney)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63557 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63557

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence R. Divinney

(a) RESIDENCE. NO. Mt Hope Retreat- ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Widow -

5a If married, widowed, or divorced (or) WIFE of Mrs Divinney

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57 years abt -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jno Divinney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Ann Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md.

15 Filed APR 18 1922 19 Robert P. Barrett Registrar

Vital Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17- 1922 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 . 1918 . to Apr 17- 1922 . 19 . that I last saw h[illegible] alive on April 17th . 1922, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular (mitral) Disease of the Heart - abt (duration) 3 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Dementia Post Chronic Mania (duration) 3 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL April 1922

20 UNDERTAKER Joseph Lowery — ADDRESS 224 B Way

mation should be carefully supplied. Avoid abbreviations. Write with ink. Do not use pencil. Each statement must be complete. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63558 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63558

CERTIFICATE OF DEATH.

99

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1178 Hanticoke St., W 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodora Smith

(a) RESIDENCE NO. 1178 Hanticoke St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, ~~widowed~~, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Oct 31-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. E. Glendenning 1178 Hanticoke St.

15 Robert J. Garrison, Registrar

APR 18 1922 Burial Permit Clerk. 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12. 1922. to April 17. 1922. that I last saw her alive on April 16. 1922. and that death occurred, on the date stated above, at 4.50. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis & Asthma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis,

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home & Hospital

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Wilson M. D.

April 19 1922 (Address) 38 S. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL April 19 1922

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca St.

B.—WRITE plainly. All items should be carefully supplied. AGE should be carefully computed. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Pinder

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63559

D 63559

CERTIFICATE OF DEATH.

31

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 Maw ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah L Pindr

(Residence in Baltimore: No. 2544 Maw St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	Colored	married

6-DATE OF BIRTH, ..., 1855
(Month) (Day) (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Rochester Md

PARENTS.

10-NAME OF FATHER, David Wangus

11-BIRTHPLACE OF FATHER (State or Country), Rochester Md

12-MAIDEN NAME OF MOTHER Sophia Tennett

13-BIRTHPLACE OF MOTHER (State or Country), Rochester Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Pinder

(Address) 2544 Maw St

15- APR 18 1922 ROBERT R. KRAUTER, Registrar.
Filed ..... 191... Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 25 1922, to April 17 1922, that I saw her alive on April 16 1922, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) Geo M Stiff M. D.

April 18, 1922 (Address) 2435 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, April 20, 1922

20-UNDERTAKER Joseph A Farrell — ADDRESS 2514 Eutaw St

N. B.—Every item of information should be entered, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63560

CERTIFICATE OF DEATH.

161-001 D 63560

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 Glyndon Ave ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Muntzell

(Residence in Baltimore: No. 1233 Glyndon Ave St.; ..... yrs., ... mos. 4 yrs.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S

6-DATE OF BIRTH, Apr 17 (Month), 17 (Day), 1922 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 1233 Glyndon Ave Baltimore Md.

PARENTS.

10-NAME OF FATHER, Lemuel R Muntzell

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co Md.

12-MAIDEN NAME OF MOTHER, Mary Ewing

13-BIRTHPLACE OF MOTHER (State or Country), Harve de Grace Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lemuel R Muntzell

(Address) 1233 Glyndon Ave

15- APR 19 1922 Filed ..... 191..... ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 18 (Month), (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 17 1922, to Apr 18 1922, that I saw h[illegible] alive on Apr 17 1922, and that death occurred, on the date stated above, at 12:05 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

Syncitia intrauterine.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Not known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Roscoe Gaines M. D.

Apr 18, 1922 (Address) 1438 Brookfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cem

DATE OF BURIAL, Apr 19, 1922

20-UNDERTAKER Robert Brockerson

ADDRESS Baltimore Md

N. B.—Every item of information should be given, so that it may be properly classified. Fill out CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63561 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63561

CERTIFICATE OF DEATH. 431

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 W. 27. St. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane B. H. Perry

(a) RESIDENCE NO. 205 W. 27th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minian M. Perry.

6 DATE OF BIRTH (month, day, and year): Apr. 12 1845

7 AGE: Years 77 — Months — Days 5 — If LESS than 1 day, ...hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hester McDaniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Minian M. Perry (Address) Bethesda Monta Co Md

15 Filed APR 1 1922 ROBERT R. KRAUTER Registrar Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15 1922 to April 17 1922, that I last saw her alive on April 17 1922, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 15 yrs. 4 mos. History ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leonard Rose Veach M. D.

19 (Address) 2251 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: April 20 1922

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 E. Fayette

N. B.—WRITE PLAINLY. AGE should be carefully supplied. Exact statement of occupation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63562

CERTIFICATE OF DEATH.

57

D 63562

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2335 Mrs Elderry ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Feldner

(a) RESIDENCE No. 2335 Mrs Elderry. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a ~~If married~~, widowed, ~~or divorced~~ (or) WIFE of ~~HUSBAND of~~ Casper Feldner

6 DATE OF BIRTH (month, day, and year) June 14-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) ~~000~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Casper Feldner

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Katherine Grobl

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Dorothy Fields

(Address) 2335 Mrs Elderry st

15 Filed APR 1 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17. 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to April 16. 1922.

that I last saw h er alive on " " 19 " ,

and that death occurred, on the date stated above, at 12.50 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes

about 2 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical

(Signed) J. H. Collenberg M. D.

(Address) 1810 ½ Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL April 19 1922

20 UNDERTAKER Geo C. Fuller

ADDRESS 2334 Jefferson st

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 63563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63563

CERTIFICATE OF DEATH.

902

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1131 N. Stockton St. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Speaks,

(Residence in Baltimore: No. 1131 N. Stockton St. 12 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year) 1887

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country). Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachael Mason

(Address) 1131 N. Stockton St.

15-

Filed APR 19 1922 ROBERT R. KRAUTER

Registrar.

Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Organic Heart disease

(b) .....

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessey M. D.
(Coroner.)

April 17, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, April 19, 1922

20-UNDERTAKER Edward Ruggold | ADDRESS 1463 Carey

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63564

D 63564

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 Cookan Raspberg St. (WARD) 7-1

2-FULL NAME Albert. Dolazil

(a) RESIDENCE NO. 3 Cook Ave Raspberg St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Francis Dolazil

6 DATE OF BIRTH (month, day, and year) March 1-1841

7 AGE	Years	Month	Days	If LESS than 1 day, hrs. or min.
	80	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Wheel Right
(b) General nature of industry, business, or establishment in which employed (or employer) 007
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not Given

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Given

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Given

14 Informant Aug. Kraska Sr. (Address) 2225 Madison

15 Filed APR 19 1922 ROBERT R. KRAUTER Registrar Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1922

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1922 to April 17, 1922

that I last saw him alive on April 17, 1922

and that death occurred, on the date stated above, at 11 AM. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) F. F. Weinberg M. D.

4-18 1922 (Address) 600 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Apr 20 1922

ADDRESS

20 UNDERTAKER Geo M. Frank & Son

ADDRESS 811 N Wolfe

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be carefully supplied. Exact statement of date of birth should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63565

D 63565

CERTIFICATE OF DEATH.

REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 N Broadway ST. 8 WARD)

2-FULL NAME Henry E. Geblein

(a) RESIDENCE NO. 1527 N Broadway ST., WARD 8
(Usual place of abode)
Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, (or) WIFE of: Sophia Geblein

6 DATE OF BIRTH (month, day, and year): July 23d 1852

7 AGE: Years 69 Months 9 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Henry Geblein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond

12 MAIDEN NAME OF MOTHER: Mrs Chamberlain

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Sophia M. Geblein
(Address) 1527 N Broadway

15 FILED APR 19 1922 Registrar

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1920, to April 17, 1922, that I last saw him alive on April 17, 1922, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) 2 yrs. 2 mos 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of Jan 25/20

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) C. W. Mackenzie M. D.

(Address) April 18, 1922 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: April 20 1922

20 UNDERTAKER: Geo M. Frick & Son

ADDRESS: 811 N Howard

N. B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. Exact statement of date of birth should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

D 63566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital St.: 21 WARD)

REGISTERED No. C 1883

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Thomas

(Residence in Baltimore: No. 226 Olerbine St.: 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 14 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Pruntytown Conn

PARENTS.

10-NAME OF FATHER, Alfred Johnson

11-BIRTHPLACE OF FATHER (State or Country) Pruntytown Conn

12-MAIDEN NAME OF MOTHER Alice Thomas

13-BIRTHPLACE OF MOTHER (State or Country) Pruntytown Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Thomas

(Address) 226 Olban St.

15- Filed APR 19 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & internal injuries

(Duration) ..... yrs. a few mos. ..... ds.

CONTRIBUTORY (Secondary) Accidentally Struck by Auto

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Gorsuch M. D.
(Coroner.)

4-19, 1922 (Address) 112 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Baltimore Md

19-PLACE OF BURIAL OR REMOVAL, Queen Chapel Church — DATE OF BURIAL, April 18, 1922

20-UNDERTAKER Mrs. Geo. H. Hopper — ADDRESS 706 W. Conway.

N.B.—Every item of information should be carefully supplied. Read the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63567.

CERTIFICATE OF DEATH.

120 D 63567.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Paludki

(Residence in Baltimore: No. 218 S. Bdway St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Widower

6-DATE OF BIRTH, nov 29, 1896
(Month) (Day) (Year)

7-AGE, 25 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ry Co

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Peter Paludki.

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER Alexandra

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Paludki

(Address) 218 S Bdway

15- Filed APR 19 1922 191 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shooting by police

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs.....mos.....ds.

(Signed) H. Smith Briscoe M. D.
(Coroner.)

4-18, 1922 (Address) 4 E. Mt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	4-20, 1922
20-UNDERTAKER	ADDRESS
John Grebbinoweski	425 S. Paca St.

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63568

CERTIFICATE OF DEATH.

D 63568

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 E Hamburg St. 7th Ward)

2-FULL NAME Frederick Arey

(a) RESIDENCE. No. 411 E Hamburg St., 7th Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 4.18.22

7 AGE: Years ... Months 8 Days 2 Month. If LESS than 1 day, 4 hrs. or ... min.

8 OCCUPATION OF DECEASED: Child 000

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Otis O Arey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Md

12 MAIDEN NAME OF MOTHER: Mary E. Arey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Mrs Mary E Arey
(Address) 411 E Hamburg St

15 Filed APR 19 1922 ROBERT K. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4.18 1922

17 I HEREBY CERTIFY, That I attended deceased from 4.18, 1922, to 4.18, 1922, that I last saw h.im alive on 4.18, 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Final Thrombosis)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Post Partum
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. J. Burlington, M. D.

4.18 1922 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: April 1922

20 UNDERTAKER: Wm J. E. Evans Sons — ADDRESS: 1429 E Pratt

N. B.—WRITE PLAINLY. All items must be carefully supplied. Age should be given in years, months and days. Every question must be properly answered. Exact information should be carefully supplied. All items must be properly classified. Exact information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63569 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D 63569

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

2-FULL NAME Henry Boland

(a) RESIDENCE. NO. 1100 Witmore ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cora Boland

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor & brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad 073

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Boland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Boltle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M. T. H.

15 APR 19 1922 ROBERT R. KRAUTER (Signature of Registrar)
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 18, 1922, that I last saw him alive on April 18, 1922, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum

(Signed) Frances L. Padgliese M. D.

4-18-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Apr 21 1922

20 UNDERTAKER John F. Cowan & Son — ADDRESS 701 Holliday St.
Per F. F. Cowan

N. B.—Items should be carefully supplied. After information should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63570

D 63570

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 W. Belvedere (Street) (Ward) 27

2-FULL NAME Charles M. Waesche

(a) RESIDENCE NO. 132 W Belvedere Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 1. 1922

7 AGE — Years | Months | Days: 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas A Waesche

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Edna E. Tilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Thomas A Waesche

(Address) 132 W Belvedere

15 Filed APR 1 9 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1922

17

I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1922, to Apr. 18, 1922,

that I last saw h in alive on Apr 18, 1922,

and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas J Wells, M. D.

, 19 (Address) 2 W Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: April 20 19 22

20 UNDERTAKER: Chenoweth Son

ADDRESS: Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 63571

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-001 D 63571

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Calvert Station, ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME E. Paul Bailey

(Residence in Baltimore: No. 3967 Hickory Av St.: Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: May 21 (Month) (Day), 1883 (Year)

7-AGE: 36 yrs. 10 mos. 27 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car Inspector
(b) General nature of industry, business, or establishment in which employed (or employer): Penn R R Co

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mary E Bailey

(Address): 3967 Hickory Av

15-

FILED APR 19 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: April 18 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest held April 19- (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Vertebra T 2
Chest Crushed
Caught between two cars
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden (Duration) yrs. mos. ds.

(Signed) W. J. Peter M. D.
(Coroner)

April, 1922 (Address) 1639 Kennedy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Saint Marys Cemetery — DATE OF BURIAL: April 20 1922

20-UNDERTAKER: Chenowith & Son — ADDRESS: Chestnut Av

N. B.—Every item of information should be carefully supplied. AGE should be correctly stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

15 5412 D 63572

HEALTH DEPARTMENT—CITY OF BALTIMORE

161 001 D 63572

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2-FULL NAME Baby Grant.

(a) RESIDENCE NO. 715 N Wallas St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Elnor Grant (mother)

6 DATE OF BIRTH (month, day, and year) April 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 [illegible] APR 19 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922. to April 14, 1922. that I last saw him alive on April 14, 1922. and that death occurred, on the date stated above, at 11 00 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? Wright 2½ lbs

(Signed) Horace G. Stewart, M. D.

4/14, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL APR 19 1922

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63573

CERTIFICATE OF DEATH.

16 D 63573

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 6 WARD)

2-FULL NAME Lena Turner

(a) RESIDENCE NO. 106 N. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days: 16 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 19 1922 ROBERT R. KRAUTE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1 1922 to April 10 1922.

that I last saw her alive on April 10 1922

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Horace G. Stewart M. D.

4/15, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 19 1922

D 63574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 63574

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert F. Meinecke

(Residence in Baltimore: No. 928 W Mulberry St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

6-DATE OF BIRTH. Mar (Month) 10 (Day) 1870 (Year)

7-AGE. 52 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Letter Carrier
(b) General nature of Industry, business, or establishment in which employed (or employer): U.S. Govt P.O.

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Frederick Meinecke

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Louisa Brandt

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Meinecke

(Address) 2284 Pappleton St

15- APR 19 1922 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 17 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot Wound — Brain Suicide

(Duration) Few minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Insanity

(Duration) ? yrs. 2 mos. ds.

(Signed) James M. Fenton M. D. (Coroner.)

4/17 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents) At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. 928 W Mulberry St

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL, April 20, 1922

20-UNDERTAKER. John O. Mitchell ADDRESS 1320 N. Fayette

N. B.—Every item of information should be properly classified, so that it may be properly tabulated. To state CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63575

CERTIFICATE OF DEATH.

D 63575

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. 001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Ellis Alvin Newton.

(a) RESIDENCE No. 3323 Piedmont Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Newton

6 DATE OF BIRTH (month, day, and year) July 14. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. J.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Wm. B. Hammill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 APR 19 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17. 1922. to April 17. 1922.

that I last saw him alive on April 17. 1922.

and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood Culture

(Signed) V B Herman, M. D.

4-17. 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: April 19. 1922

20 UNDERTAKER: John A. Mitchell — ADDRESS: 1201 W. Fayette

N. B. ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 63576

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 111 N Pearl ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosella Mann Hamilton

(Residence in Baltimore: No. 111 N Pearl St. 20 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Md

6-DATE OF BIRTH, 5 (Month) Apr (Day), 1877 (Year)

7-AGE, 45 yrs. 0 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jos Mann

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ella Dawson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Hamm

(Address) 111 Pearl

15-

Filed APR 19 1922 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 15 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 14 1922, to Apr 15 1922, that I saw h[illegible] alive on Apr 15 1922, and that death occurred, on the date stated above, at 6.15 m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

4 hrs

(Duration) mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of heart

(Duration) 1 yrs. mos. ds.

(Signed) Wilkam E. Burlen M. D.

Apr 17, 1922 (Address) 762 Druid Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery

DATE OF BURIAL, 4-19-22

20-UNDERTAKER R C Gross

ADDRESS 1405 McElderry

N.B.—Every item of DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.V.HOSP.#56,

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Moore

(a) RESIDENCE NO. U.S.V.Hosp.#56,Ft.McHenry,Md ST., WARD 43

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
59	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of Industry, business, or establishment in which employed (or employer) ---

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T.Rosenbrock, Registrar

(Address) U.S.V.Hosp.#56,Ft. McHenry,Md.

15 Filed APR 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 14,1921. 19..... to Apr.18,1922. 19.....

that I last saw him alive on April 18, 1922.

and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertropic Arthritis

Arterio Sclerosis (general) Tabes Dorsalis

Transitory Monoplegia (cortical in origin)

--- (duration) -- yrs. - mos -- ds.

CONTRIBUTORY (Secondary) Hemorrhage, cerebral

-- (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical Report

(Signed) M.A. Foster, M. D.

4-18-22 (Address) Surgeon,U.S.P.H.S. U.S.V.Hosp.#56,Ft.McHenry,Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity St. Cemetery	April 20 1922
UNDERTAKER Louis Heemann	ADDRESS 22 S Broad St

N. B. Information should be carefully supplied. Note that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63578 ✓ 49 D 63578

D 63578

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

2-FULL NAME Mrs. Georgia Baylis

(a) RESIDENCE NO. 2 Lansdowne Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 3 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late C.K. Baylis

6 DATE OF BIRTH (month, day, and year) Nov. 22-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67 yrs.	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Not any

(c) Name of employer

9 BIRTHPLACE (city or town) ... Va
(State or country)

PARENTS

10 NAME OF FATHER William Atkins

11 BIRTHPLACE OF FATHER (city or town) ... Va
(State or country) "

12 MAIDEN NAME OF MOTHER Elizabeth Layton

13 BIRTHPLACE OF MOTHER (city or town) ... Va
(State or country) " "

14 Informant Mrs. Wm. Atkins
(Address) 3752 Calvert St.

15 Filed APR 19 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1922, to April 18, 1922

that I last saw h alive on April 18, 1922

and that death occurred, on the date stated above, at 11:40 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas
Metastasis to Liver
Weak & nervous for
Years — (duration) ... yrs. 14 mos ... ds.

CONTRIBUTORY (Secondary) Asthenia Complete
(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ... Date of 2-27-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X Ray

(Signed) ... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Apr. 20 1922

20 UNDERTAKER George L. Schwab — ADDRESS 3101 Fulton Ave

N. B.—WRITE plainly. All items should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63579

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 63579

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2318 Fenmore ST.: 13 WARD)

2-FULL NAME Morgart L Snoek.

(a) RESIDENCE. No. 2318 Fenmore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen R Snoek

6 DATE OF BIRTH (month, day, and year): Autumn

7 AGE: 35 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housebuilder

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Richard Corcoran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Morgart Talley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs R Snoek
(Address) 2318 Fenmore

15 Filed APR 19 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1921, to Apr 18, 1922, that I last saw h alive on Apr 18, 1922, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Cor Cancer of uterus

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J F Mellen, M. D.

, 19 (Address) 13 SW Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Southern Cem

DATE OF BURIAL: Apr 20 192

20 UNDERTAKER: Martin Lackey

ADDRESS: 837 W North

A. B. C. information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 63580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 63580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1957 N Collington ave ST., 8 WARD)

2-FULL NAME Leivenia P Phipps.

(a) RESIDENCE NO. 1957 N Collington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	39	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John B Phipps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary E Phipps (Address) 1957 N Collington Ave

15 FILED APR 19 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1922, to April 17, 1922, that I last saw h[illegible] alive on April 17, 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) W. E. Harris, M. D.

April 19 1922 (Address) 1301 N Rose St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camp Parol Md. DATE OF BURIAL April 20 1922

20 UNDERTAKER Robt J Turner Inc ADDRESS 1402 N Broadway

N. B.—WRITE should be carefully supplied. Age should be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 63581

REGISTERED NO. D 63581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 E. North Ave. (ST.,) 19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kirkwood Dick

(a) RESIDENCE NO. 1401 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Dick

6 DATE OF BIRTH (month, day, and year) April 18, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	78	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or couutry) Scotland

PARENTS

10 NAME OF FATHER James Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Helen Laird

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant James K Dick

(Address) 1917 E Lafayette

15 Filed APR 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1922, to Apr 18, 1922,

that I last saw h.W alive on Apr. 18, 1922,

and that death occurred, on the date stated above, at 7.40 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

4/18 1922 (Address) 1823 N. Hast st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 4/20 1922

20 UNDERTAKER E. J Fanning & Son 1938 E Lafayette — ADDRESS

N. B.—WRITE plainly. All items should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be given. Information should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63582

CERTIFICATE OF DEATH.

91 D 63582

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 S. Linwood Ave. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Franklin

(a) RESIDENCE. No. 5 South Linwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Franklin

6 DATE OF BIRTH (month, day, and year) July 7/1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Va.

PARENTS

10 NAME OF FATHER Judson Traylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Henry Franklin
(Address) 5 S. Linwood Ave

15 APR 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 28 19 22, to Apr 18 19 22, that I last saw h alive on Apr. 17 19 22, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Aortic - Sclerosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Dissection Dr Bagley

(Signed) [illegible], M. D.

(Address) 1431 Eutaw, April 19 19 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Apr. 20 1922
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

mation should be carefully supplied. And should be properly classified. Exact statement of disease CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.
Not apoplectic

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63583

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Light ST.: 23 WARD)

2-FULL NAME Mary E Pardoe

(a) RESIDENCE. NO. 1020 Light ST. 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late William Pardoe

6 DATE OF BIRTH (month, day, and year) March 27 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER Caleb Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ethel Mortimer
(Address) 1020 Light St

15 Filed APR 19 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to April 18, 1922;
that I last saw her alive on April 17, 1922
and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with metastasis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) [illegible], M. D.

Apr 1 1922 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	April 20 1922

20 UNDERTAKER Mrs J E Evans & Sons ADDRESS 1720 E Lanvale

INFORMATION should be carefully supplied. All items should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63584

CERTIFICATE OF DEATH.

179

D 63584

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2701 Riggs Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Woods

(a) RESIDENCE. No. 2701 Riggs Av ST., 16 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? 65 yrs. 11 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Robert Woods

6 DATE OF BIRTH (month, day, and year) About May-13-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	65	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Dikel

11 BIRTHPLACE OF FATHER (city or town) (State or country) northnown Germany

12 MAIDEN NAME OF MOTHER Catherine ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country) northnown Germany

14 Informant Miss Beulah L. Woods (daughter)

(Address) 2701 Riggs Ave

15 APR 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17

I HEREBY CERTIFY, That I attended deceased from April 10th, 1922, to April 18th, 1922,

that I last saw h[illegible] alive on April 18th, 1922,

and that death occurred, on the date stated above, at 12-15 Pm.

The CAUSE OF DEATH* was as follows:

Multiple Hamitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual examination

(Signed) H. D. Hammett, M. D.

, 19 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Apr-20-1922

20 UNDERTAKER: Jos. Joerdens Son — ADDRESS: 217-S-Paca St

N. B.—WRITE mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may

Spec.—1-10-21—M&T—1500 Bks.

D 63585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1729 D 63585

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Bradley ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Justice

(a) RESIDENCE NO. 615 Bradley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 12 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	33	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) D & O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ashland Ky

PARENTS

10 NAME OF FATHER Lewis Justice

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Rudgens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ashland Ky

14 Informant Grant Justice

(Address) 509 Richmond St Locust Point

15 Filed APR 19 1922

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 15, 1922

that I last saw him alive on April 15, 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Asthma Dropsy & Bright Disease

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease Asthma Dropsy

(duration) yrs. 4 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. G. Lemmard, M. D.

4-15-1922 (Address) 620 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Apr 19 1922
20 UNDERTAKER Samuel T Hemsley	ADDRESS 578 W Baltimore St

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D-63586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63586

D 63586

CERTIFICATE OF DEATH.

D 63586

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St Agnes Hospital WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Johnson.

(a) RESIDENCE NO. 430-7th Ave - Roanoke WARD Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68 yrs	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Donal Brand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mrs James Carmony

(Address) 1248 Lesley Ave

15 Filed APR 19 1922 Robert R. Knauer, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to Apr. 17, 1922 that I last saw h-m alive on Apr 17, 1922 and that death occurred, on the date stated above, at 6:25 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 3 hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-17-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Question

(Signed) L.O.C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL April 20th 1922

20 UNDERTAKER Leo. G. Good

ADDRESS North Harford

NOTICE—Information should be carefully supplied. AGE must be given in every case. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63587

CERTIFICATE OF DEATH.

D 63587

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob S. Lang

(a) RESIDENCE. NO. Winchester, Md. ST., ... WARD. Winchester Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer - Ofo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) France.

12 MAIDEN NAME OF MOTHER Louise Friedhoffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant E. J. Kemp
(Address) Annapolis R.D. #2

15 Filed APR 19 1922 H E Walsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1922, to April 18, 1922, that I last saw him alive on April 18, 1922, and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) — yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic insufficiency.

(duration) 2 yrs. — mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) R B Jones, M. D.

4/21, 1922 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	4/20/1922
20 UNDERTAKER	ADDRESS
Wm Cook,	502 E. North ave

N. B.—[illegible] mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63588 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 43 D 63588

1-PLACE OF DEATH University Hospital.

CITY OF BALTIMORE: (No. Lombard & Greene ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Harriet May.

(a) RESIDENCE. NO. 1112 Cookery St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of Ralph C. May.

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm Parr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eva. McGaulry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Ralph May

(Address) 1112 Cookery St.

15 Filed APR 19 1922 H. H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 1922, to 4/18, 1922

that I last saw h alive on 4/18, 1922

and that death occurred, on the date stated above, at 10 50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension

Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy - aborting

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Thos Madden M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	apr. 20, 1922

20 UNDERTAKER Wm Leask, 507 E. North ave ADDRESS

mation should be carefully supplied. AGE should be properly classified. Exact statement of
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 63589

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1047 Argyle Ave. (WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Quinn

(a) RESIDENCE. NO. 1047 Argyle Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) 4/16/22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Jacob Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pocomoke Md.

12 MAIDEN NAME OF MOTHER Grace Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Grace Quinn

(Address) 1047 Argyle Ave

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/16, 1922, to 4/18, 1922, that I last saw her alive on 4/17, 1922, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ———

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm. Ross Kelly, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL April 20 1922

20 UNDERTAKER David Easton

ADDRESS 916 Pa Ave

N. B. ... mation should be carefully supplied. ... should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 63590

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 718 Fremont Ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cramer.

(a) RESIDENCE. NO. 718 Fremont Ave St., WARD. 71 - U.S.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Cramer.

6 DATE OF BIRTH (month, day, and year) April 26 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Locke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Theodore Feudy (Address) 817 E 22nd St

15 Filed 19 Registrar

Robert L. [illegible]

Burial Permit Clerk.

APR 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18- 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1922, to April 18, 1922, that I last saw h.r alive on April 17, 1922, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Senility, Myocarditis

Arterial Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

Attack, (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Acute Attack Heart

(Signed) Thos. H. Reilly, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	April 21 1922
UNDERTAKER	ADDRESS
E. A. Tredgett Jr	501 E 22nd St.

mation should be carefully supplied. Note that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 63591 — REGISTERED NO. 129 D 63591

(PLACE OF DEATH — CITY OF BALTIMORE (No. 1604 E. Oliver ST. WARD) — (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Henry Ellen Chard

(Residence in Baltimore: No. 1604 E Oliver St) — St.: 79 yrs. approximately

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: February 27, 1843 (Month) (Day) (Year)

7-AGE: 79 yrs. 2 mos. ds. — If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Kentucky

PARENTS

10-NAME OF FATHER: Henry Young.

11-BIRTHPLACE OF FATHER (State or country): Kentucky

12-MAIDEN NAME OF MOTHER: Mary

13-BIRTHPLACE OF MOTHER (State or country): Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Jane Chard

(Address) 1604 Oliver St

15-

Filed APR 19 1922 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Apr 18 (Month) (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15, 1922, to Apr 18, 1922, that I saw h[illegible] alive on Apr 17, 1922, and that death occurred, on the date stated above, at 7:30A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ... yrs. ... mos. 3 ds

Contributory (SECONDARY): Chronic Nephritis (Duration) Indefinite ds.

(Signed) H E Chatz M. D.

Apr 18, 1922 (Address) 1107 N Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel Church Cem a.a.Co. — DATE OF BURIAL: April 20, 1922

20-UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B.-Every item of information should be carefully supplied. AGE should be stated [illegible]. Exact statement of OCCUPATION is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63592

CERTIFICATE OF DEATH.

154-002

D 63592

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 221 E Grindall ST., 24 WARD)

2-FULL NAME William H. Roeder

(a) RESIDENCE NO. 221 E Grindall ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm C Roeder

11 BIRTHPLACE OF FATHER (city or town) Balto,
(State or country)

12 MAIDEN NAME OF MOTHER Anna Siland

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Wm C Roeder
(Address) 221 E Grindall

15 Filed Apr 19 1922 Robert P. Harrison, Registrar

APR 19 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1922, to April 19, 1922, that I last saw h.. alive on April 18, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C Mitchell, M. D.

April 19, 1922 (Address) 1299 Mills Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL April 20 1922

20 UNDERTAKER Wm Cook — ADDRESS A + B Ave

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1922 D 63593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63593

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 7 WARD)

2-FULL NAME Spencer Katze

(a) RESIDENCE NO. 615 W. 162 St. ST., WARD New York City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adele Katze

6 DATE OF BIRTH (month, day, and year) Dec. 6th 1891

7 AGE	Years	Months	Days	If LESS than 1 day, brs. or ..... min.
	30	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Male

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Albert Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Rachel Hess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisiana

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Friends.

APR 19 1922

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1922

17

I HEREBY CERTIFY, That I attended deceased from , 19 , to April 17th 1922,

that I last saw h me alive on April 17th 1922,

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

I Brain Tumor

Finial.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E Dandy, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York N.Y.

DATE OF BURIAL April 19 1922

20 UNDERTAKER Joseph Ahrens

ADDRESS 224 W Penna

mation should be carefully supplied. AGE must be properly classified. Exact settlement of
AUSE OF DEATH in plain terms, so that it may be properly classified.
ON is very important. See instructions on back of certificates.

D 63594 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63594

CERTIFICATE OF DEATH.

REGISTERED No. C 1917

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 526 n Patterson Pk ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank W. Smith

(Residence in Baltimore: No. 526 n Patterson Pk. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Fireman
(b) General nature of industry, business, or establishment in which employed (or employer). R. R. Co

9-BIRTHPLACE. (State or Country), City

PARENTS.

10-NAME OF FATHER, Frank Smith

11-BIRTHPLACE OF FATHER (State or Country). Ger

12-MAIDEN NAME OF MOTHER Augusta Schmidt

13-BIRTHPLACE OF MOTHER (State or Country). Ger

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Aug Smith

(Address) 4th Ave

15- Filed ..., 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

R 19 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Gun shot

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. Kurtz Smith M. D. (Coroner.)

1-19-22, 191.. (Address) 4th Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, April 21, 1922

20-UNDERTAKER Peter Nicolaus

ADDRESS 2046 Eastern Ave

8.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63595

CERTIFICATE OF DEATH.

90 D 63595

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20 N Pobblelon ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Marshall.

(Residence in Baltimore: No. 20 N. Pobblelon St 20 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Marble Worker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 376

9-BIRTHPLACE. (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Kn

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Kn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mildred Marshall

(Address) 21 E. Lee St

15- Filed APR 2 01922 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(Duration) Don't Know ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Jones M. D. (Coroner.)

4-19..., 1922 (Address) 11 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, April 20 1922

20-UNDERTAKER John H. Trodden

ADDRESS 142 W. Fayette St

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63596 ✓ D 63596

REGISTERED NO.

D 63596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 Princeton Pl ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Stinz

(a) RESIDENCE. NO. 300 Princeton Pl ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE 40 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED 041

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha Gutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sallie Holmes (Address) 300 Princeton Pl

15 Filed APR 2 01922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from March 24th 1922, to April 19, 1922, that I last saw h[illegible] alive on April 18, 1922, and that death occurred, on the date stated above, at 9 10 A m.

The CAUSE OF DEATH* was as follows: Acute Rheumatic Fever and Endocarditis

(duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Rheumatic Fever (duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Cecil Hall, M. D.

, 19 (Address) 426-6 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: King George Co Va — DATE OF BURIAL: 4-20 1922

20 UNDERTAKER: George W. Holland — ADDRESS: 163 Lewis Hillsman

make sure that the cause of death is properly classified. Write CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63597 ✓ D 63597

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillsdale, Baltimore, Md ST., 28 WARD)

2-FULL NAME Carrie Hutton

(a) RESIDENCE NO. Hillsdale, Baltimore, Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonathan Hutton

6 DATE OF BIRTH (month, day, and year) Apr. 28th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg Grant Co
(State or country) W. Va.

PARENTS

10 NAME OF FATHER Felix Welton

11 BIRTHPLACE OF FATHER (city or town) Petersburg Grant Co
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mahala Hyre

13 BIRTHPLACE OF MOTHER (city or town) Petersburg Grant Co
(State or country) W. Va.

14 Informant Edward S. Hutton
(Address) Hillsdale, Baltimore, Md.

15 Filed APR 20 1922 ROBERT A. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1922, to Apr 18, 1922, that I last saw h.. alive on April 17, 1922, and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arnold M. Spurrier, M. D.

Apr. 20, 1922 (Address) Catonsville, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery — DATE OF BURIAL Apr. 20th 1922

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Baltimore St

mation should be entered, words should be spelled out, so that it may be properly classified.
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63598 ✓ D 63598

D 63598

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 Ajax ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Anderson

(a) RESIDENCE. No. 724 Ajax ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) For Herself

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Burdley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Mary Anderson (Address) 724 N Gay St. Balt

15 Filed APR 2 01922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1922, to April 17th, 1922, that I last saw her alive on April 16th, 1922, and that death occurred, on the date stated above, at 6 Oclock a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. 3 mos. 16 ds.

CONTRIBUTORY (Secondary) A severe Cold With Bronchial Debility (duration) yrs. 2 mos. 16 ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel J Bell, M. D

, 19 (Address) 1576 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL April 20 1922

20 UNDERTAKER Wm Robert A Elwood Sons

ADDRESS 1725 Pa Ave

mation should be entered, ... CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63599

188 B 03 63599

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Mercy Hosp ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angela Eagan

(Residence in Baltimore: No. 229 S. Ann St.; yrs., mos. ds.)

18

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug. (Month) 21 (Day), 1901 (Year)

7-AGE, 20 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, M. Eagan

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Katherine Repp

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Eagan

(Address) 229 Ann

15- Filed APR 20 1922 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 18 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) will be held Apr 24 — thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull — Caused by either Falling or Thrown from auto (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C.C. Ruly M. D. (Coroner)

Apr 20, 1922 (Address) W.S.P. Co

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland

DATE OF BURIAL, 4/22, 192

20-UNDERTAKER Mahon Co

ADDRESS SOLENOTH

N. B.—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D 63600

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 5219 Park Heights Ave ST., 27 WARD)

2-FULL NAME Vera Sullivan

(a) RESIDENCE NO. 5219 Park Heights Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Aug 23-1911

7 AGE — Years: 10 — Months: 10½ — Days: ..... — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 000

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Charles Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): .....

12 MAIDEN NAME OF MOTHER: Edith Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Whales England.

14 Informant: JOHNS HOPKINS HOSPITAL Records.
(Address)

15 FILED APR 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 18, 1922, that I last saw her alive on April 18, 1922, and that death occurred, on the date stated above, at 10 20/a.m.

The CAUSE OF DEATH* was as follows:

Empholetis, Epedimic

..... (duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) T. B. Gay, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 4/22 1922

20 UNDERTAKER: William Cook — ADDRESS: 502 E. North Ave

mation should be carefully supplied. AGE should be stated [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63601

CERTIFICATE OF DEATH.

84 D 63601

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 E Federal ST., 8 WARD)

2-FULL NAME Henry Theis

(a) RESIDENCE No. 2503 E Federal ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda Theis

6 DATE OF BIRTH (month, day, and year): Dec 28/1853

7 AGE: Years 68 | Months 3 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watch 039

(b) General nature of industry, business, or establishment in which employed (or employer): Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pfalzgrafenweiler Germany

PARENTS

10 NAME OF FATHER: Charles Theis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Matilda Theis (Address) 2503 E Federal St

15 APR 20 1922 EG Registrar

Dr. Miller 150 N Broadway

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 22

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1922, to April 18, 1922, that I last saw him alive on April 18, 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical sign & Symptoms

(Signed) Dr. Miller, M. D.

, 19 (Address) 150 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: April 21 1922

20 UNDERTAKER: William Lee | ADDRESS: 502 E Fayette

mation should be carefully supplied. Fa... CAUSE OF DEATH in plain terms, so that it may be properly classified. Ea... TION is very important. See instructions on back of certificates.

Buehner ✓

63602

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 Arlington

REGISTERED NO. C. D. 63602

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Belvieu Ave. St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Buehner

(Residence in Baltimore: No. 4101 Belvieu Ave. St.; 68 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Aug 14, 1840 (Month) (Day) (Year)

7-AGE: 81 yrs. 8 mos. 4 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Frederick Giede

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Dybusch

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Nannie Buehner

(Address) 4101 Belvieu Ave

15- Filed APR 20 1922 ROBERT N. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 4 (Month) 18 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/12, 1922, to, 4/17 1922, that I saw h[er] alive on 4/17 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage, arterio-sclerosis

(Duration) yrs mos. 5 ds.

Contributory (SECONDARY)

(Duration) yrs mos. ds.

(Signed) Henry Russell M. D.

4/18, 1922 [Address] 3902 Groveland Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: April 20, 1922

20-UNDERTAKER: J. M. Rowton

ADDRESS: 2238 N. North

N. B.—Every item of information should be given, so that it may be properly classified. Especially state CAUSE OF DEATH in plain terms, so that it may be properly classified. PARTICULAR ATTENTION is very important. See instructions on back of certificate.

Leaman

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63603

D 63603

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2200 Chelsea Ter., 15 WARD)

2-FULL NAME Virginia Leaman

(a) RESIDENCE NO. 2200 Chelsea Ter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. —— mos. —— ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hezakiah Leaman

6 DATE OF BIRTH (month, day, and year) March 29 70

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country) ~~Lowdon~~

PARENTS

10 NAME OF FATHER Lowden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Folks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Wm Windsor
(Address) 2200 Chelsea Ter

15 Filed APR 20 1922 ROBERT R. KRAUTH Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922, to April 19, 1922, that I last saw her alive on April 18, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(duration) yrs. mos 2 ds.

Endocarditis & Interstitial Nephritis

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Phys. Exam. & Urine Exam.

(Signed) G. W. Bellups, M. D.

, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gaithersburg Md

DATE OF BURIAL April 21 1922

20 UNDERTAKER W M Rowson

ADDRESS 2238 W North Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63604 CERTIFICATE OF DEATH. 129 D 63604

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2055-Kennedy-Ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME EDWARD THOMAS JOHNSON.

(a) RESIDENCE. No. 2055-Kennedy-Av. ST., 9 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? 41 yrs 9 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Callis Johnson.

6 DATE OF BIRTH (month, day, and year) June-26-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	9	23	

008

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper in the

(b) General nature of industry, business, or establishment in which employed (or employer) Accounting Dep't.

(c) Name of employer B. & O.R.R.Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo.M.Johnson.

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E.Owens

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland.

14 Informant Mrs.Mary Callis Johnson (wife)

(Address) 2055-Kennedy-Av., City.

15 Filed APR 2 01922 ROBERT R. KRAUT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 10 1921 to April 18 1922.

that I last saw h[im] alive on April 17 1922.

and that death occurred, on the date stated above, at 3.05 p.m.

The CAUSE OF DEATH* was as follows:

~~Chronic~~

Myocardial Insufficiency

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis Chronic Diffuse

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry W. Stein, M. D.

4/18, 1922 (Address) 1315 Lex Royal Crt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY	Apr-21-22

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOOSAM, Successor) ADDRESS 108 W. NORTH AVE

mation should be carefully written in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63605 ✓ X 38 D 63605

D 63605 CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home-Infirmary ST., 6 WARD)

2-FULL NAME Walter Ray McComas

(a) RESIDENCE NO. Church Home-Infirmary ST., 6 WARD (Bel-Air, Md)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? 41 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Mabel Reckord McComas.

6 DATE OF BIRTH (month, day, and year) About 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	About 41	?	?	

8 OCCUPATION OF DECEASED 042

(a) Trade, profession or particular kind of work State's Attorney for

(b) General nature of industry, business, or establishment in which employed (or employer) Harford Co., Md.

(c) Name of employer (Self and Harford Co.)

9 BIRTHPLACE (city or town) Harford Co.,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Alexander McComas.

11 BIRTHPLACE OF FATHER (city or town) Harford Co.,
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Hannah Eliz. Carr

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.
(State or country) Maryland.

14 Informant by 'phone, Mrs. Mabel R. McComas (wife)
(Address) Bel-Air, Md.

15 Filed APR 20 1922 ROBERT R. KRAUSE Registrar

mation should be carefully supplied, so that it may be properly classified. EACH
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to April 18, 1922, that I last saw h[illegible] alive on April 17, 1922, and that death occurred, on the date stated above, at 4:55 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Encephalitis.
Chronic Alcoholism.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lues -
(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Methods

(Signed) Richard G. Corbett, M. D.

, 19 (Address) C W Md S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bel-Air, Harford Co., Md.

DATE OF BURIAL Apr-21-22

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Bks.

Joseph Guy. 91-092

D 63606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63606

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 N. Mole ST., 8 WARD)

2-FULL NAME Joseph Guy

(a) RESIDENCE NO. 1811 N. Mole ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 29/1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Guy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Gourley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E Sunkam

(Address) 1811 N Mole

15 FILED APR 20 1922 ROBERT R. KNAUER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to April 19, 1922, that I last saw h[illegible] alive on April 19th, 1922, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 2 yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Shen, M. D.

19 (Address) 1701 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville

DATE OF BURIAL Apr 22 1922

20 UNDERTAKER Edith J Jones

ADDRESS 1701 E Eager

May be properly classified. Each question should be carefully supplied, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 63607

CERTIFICATE OF DEATH.

1922 D 63607

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2142 Mt. Holly ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard Fillmore Geipe

(a) RESIDENCE. No. 2142 Mt. Holly ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Elizabeth Geipe

6 DATE OF BIRTH (month, day, and year) 18th June 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Est. agent.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Mrs. A. J. Gith.

9 BIRTHPLACE (city or town) (State or country) Shrewsbury, Pennsylvania

PARENTS

10 NAME OF FATHER Benjamin Geipe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rachel Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Maria E. Geipe
(Address) 2142 Mt Holly St.

15 Filed APR 20 1922 ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 31st, 1922, to April 19th, 1922, that I last saw him alive on April 18th, 1922, and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. W. Dybuk, M. D.

, 19 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL APR 21 1922 19

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

D 63608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 63608
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 611 Calverton Rd. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. M. Strahler

(Residence in Baltimore: No. 611 Calverton Rd. St.; 68 yrs., mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, March 19, 1854
(Month) (Day) (Year)

7-AGE, 68 yrs. mos. 22 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Sebastian Strahler

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Eva Bess

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Mrs. C. F. Strahler

(Address)..611 Calverton Rd.

15-APR 20 1922 ROBERT R. KRAUTER,
Filed....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Pul. Tuberculosis

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) J. S. Hemmeter, M. D.
(Coroner.)

April 19, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL ~~OR REMOVAL~~. Western — APR 22 1922, 19....

20-UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

D 63609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63609

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1502 Boyle St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Shepke. St.; yrs. mos. ds.)

(Residence in Baltimore: No. 1502 Boyle St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White.

5-Single, Married, Widowed or Divorced, (Write the word.): Single.

6-DATE OF BIRTH: 9.45 P.M. April 17th. 1922. (Month) (Day) (Year)

7-AGE: ---- mos. ---- ds.

If LESS than 1 day, 4 hrs. or 30 min.*

8-OCCUPATION: (a) Trade, profession, or particular kind of work: None. (b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Michael Shepke.

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Margaret Clark.

13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Shepke. (father)

(Address) 1502 Boyle St.

15-

Filed APR 20 1922 192 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17th. 1922. 5.15 P.M. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth.

unknown. ds.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto R. Ernhardt (Coroner) M. D.

April 18 1922 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, Apr 19 1922

20-UNDERTAKER, Margaret G. Flynn ADDRESS 1422 Eutaw St.

State CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. This is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63610

CERTIFICATE OF DEATH

South Balt. General Hospital 14-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Balt. General Hospital

CITY OF BALTIMORE: (No. 1213 Light ST.; 18 WARD)

2-FULL NAME Mrs. Annie E. Walker

(a) RESIDENCE. No. 1312 W. Fayette ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Walker

6 DATE OF BIRTH (month, day, and year) June 3 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aberdeen Md.

PARENTS

10 NAME OF FATHER John Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William R. Walker (Address) 1600 W. Lafayette St

15 Filed APR 20 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1922, to April 18, 1922, that I last saw her alive on April 18, 1922, and that death occurred, on the date stated above, at 11 25 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

5 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carl F. Benson, M. D.

, 19 (Address) South Bald. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Grove Presbyterian Cemetery Aberdeen Md. DATE OF BURIAL April 20 1922

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

Information should be carefully supplied. Each statement may be properly classified. Exact statements are required. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63611

100-001

D 63611

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216. N Norris ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris A Scott.

(a) RESIDENCE. NO. 2165 Norris ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 mos. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Gerald Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ada Pickett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Gerald Scott (Address) 216 N Norris st

15 FILED APR 20 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/13, 1922, to 7/19, 1922,

that I last saw h[illegible] alive on 4/7/22, 19....,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19.. (Address) 1300 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 21 1922
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

Spec.—1-10-21—M&T—1500 Bks.

63612 877 HEALTH DEPARTMENT—CITY OF BALTIMORE 63612

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 19 WARD)

2-FULL NAME Dorothy E. Munn.

(a) RESIDENCE No. 2223 Barclay St. City WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (of) ~~WIFE of~~: alice Munn. (motha),

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1918.

7 AGE: Years 3 yrs. Months 8 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Munn.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Alice Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: JOHNS HOPKINS HOSPITAL. (Address): Records

15 Filed APR 2 01922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1922 to April 18, 1922, that I last saw her alive on April 18, 1922, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

(duration) ... yrs. 3 mos ? ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) ... yrs. 1 mos ? ds.

18 Where was disease contracted if not at place of death? 2223 Barclay St.

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) H. A. Mecah, M. D.

, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL 4/21/22

20 UNDERTAKER: George J. Ruth

ADDRESS 1735 Harford Ave.

mation should be entered, so that it may be properly classified.
CAUSE OF DEATH in plain terms,
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of Scarlet Fever

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63613

D 63613

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1016 St Paul ST.: | | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick M. Colston

(a) RESIDENCE. No. 1016 St Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of: Clara C. Colston

6 DATE OF BIRTH (month, day, and year): Oct 1st 1835

7 AGE: Years 86 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: J Colston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: E. P. Tutt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: G. C. Colston (Address) 3 Calvert St

15 Filed APR 2 0 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1921, to April 19th, 1922, that I last saw him alive on April 19th, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

a Hypertension

Arterio-Sclerosis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute oedema of Lungs a few minutes (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gordon Carlson, M. D.

(Address) 4 E. Preston St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: April 21 1922

20 UNDERTAKER: Henry Jenkins Sons Co

ADDRESS: Eutaw and Fayette

Marine Shooting CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 63614

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Baby Sherwood

(a) RESIDENCE NO. 53 N. Exeter ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... (duration) ..... yrs. ..... mos ..... ds.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Mildred Sherwood

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) .....

15 Filed APR 2 01922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1922 to April 14th, 1922.

that I last saw him alive on April 14th, 1922,

and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) ..... yrs. — mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Horace G. Stewart, M. D.

4/15, 19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL APR 19 1922 19

20 UNDERTAKER .....

ADDRESS .....

mation should be entered, so that it may be properly classified.
CAUSE OF DEATH in plain terms,
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63615

CERTIFICATE OF DEATH.

HD 63615

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 E. Monument ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Lipke

(a) RESIDENCE. No. 628 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B. Lipke

6 DATE OF BIRTH (month, day, and year) Feb 16 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Rumpel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Brandtheyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John B. Lipke (Address) 628 E. Monument ave

15 Filed APR 2 01922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1922

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1922, to April 17, 1922, that I last saw her alive on April 17, 1922, and that death occurred, on the date stated above, at 6-50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? C. L. Lore

(Signed) C. L. Lore, M. D.

4/19, 1922 (Address) 8701 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	April 2 1922
20 UNDERTAKER	ADDRESS
Wendell & Leppelton	37 Lexington

Marriage CAUSE OF DEATH in plain terms, so that it may be properly classified. Physician's property to fill out certificates.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63616

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63616

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 S Conn ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam J Franz Jr

(a) RESIDENCE NO. 519 S Conn ST., WARD 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 5 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Adam J Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Margaretha Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Adam J Franz (Address) 519 S Conn

15 APR 2 01922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1922, to April 18, 1922, that I last saw h— alive on April 18, 1922, and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Influenza (Pulmonary)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Valentine, M. D.

4/22 1922 (Address) 1 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 21922
20 UNDERTAKER	ADDRESS
Wendell Duffy & Sons	318 Conn

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63617

CERTIFICATE OF DEATH.

52 D 63617

REGISTERED NO.....

D 63617
1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1644 Belt N. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. G Schmuck

(a) RESIDENCE. NO. 1644 Belt ST., 24th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Schmuck.

6 DATE OF BIRTH (month, day, and year) May 28-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpet Layer 086
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Geo Schmuck.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Hoffmann
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Schmuck
(Address) 1644 Belt N

15 APR 20 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to April 18, 1922, that I last saw h[illegible] alive on April 17, 1922, and that death occurred, on the date stated above, at 5.05 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis Rheumatism (duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4-20 1922 (Address) 1571 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co

DATE OF BURIAL 4-20 1922

ADDRESS

20 UNDERTAKER E & B Hahn 115 E Lexington St

Information should be carefully supplied. Avoid [illegible] that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63618

D 63618

CERTIFICATE OF DEATH.

11-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2328 E. Baltimore ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kelly

(a) RESIDENCE NO. 2328 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	8		

8 OCCUPATION OF DECEASED 061

(a) Trade, profession or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) Patrolman

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER B. Sinnard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mrs. Kelly
(Address) 2328 E. Baltimore st.

15 FILED APR 20 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1922, to April 18th, 1922,

that I last saw him alive on April 17th, 1922,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Dilatation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J W Revere M. D.

4/19/1922 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 4/22/22

20 UNDERTAKER John A. Moran — ADDRESS 3000 E Baltost.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Kocent.

D 63619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63619

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 S Bonner St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antoni Kocent

(a) RESIDENCE NO. 1123 S Bonner St., 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): 1853 June 8

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or ..... min.
68		10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer ~~Farmer Helper~~ 0440

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Maciej Kocent

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Maryanna Kocent (Address) 1123 S Bonner St

15 Filed APR 20 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 18 1922

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to Apr. 18, 1922, that I last saw h— alive on Apr. 18, 1922, and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Chr. Myocarditis

Mitral Insufficiency

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Nathan Davidson, M. D.

, 19 (Address) 303 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: April 21 1922

20 UNDERTAKER: Stephan Fralkowski — ADDRESS: 000 S Kenwood

N. B. Information should be carefully supplied. AGE must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACTITUDE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63620

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63620

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 704 So. Durham ST., V WARD)

2-FULL NAME Frank Niemczyk

(a) RESIDENCE NO. 704 S. Durham ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16-1893.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tin painting,

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Southren Can Company

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Andrew Niemczyk,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mollie Pichocka,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Andrew Niemczyk, (Father)
(Address) # 704 So. Durham Street

15 APR 2 01922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1918 to April 18 1922.

that I last saw him alive on April 18 1922

and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Locomator Ataxia
(non-syphilitic)

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) (M) Abramowitz, M. D.

4/19 1922 (Address) 1707 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. STANISLAUS CEMETERY

DATE OF BURIAL APRIL 22 1922.

20 UNDERTAKER M. J. Sadowski.

ADDRESS 705 S. Ann St

mation should be carefully supplied, so that it may be properly classified. EXACT
CAUSE OF DEATH in plain terms,
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63621

CERTIFICATE OF DEATH.

REGISTERED NO. C 74 B 001 63621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Gilmor ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Malinda Gaskins

(Residence in Baltimore: No. 506 N. Gilmor St. St.; 14 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March (Month) 14 (Day), 1868 (Year)

7-AGE, 54 yrs. 0 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): D70

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Allen Robinson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Lucy Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Josephs (Daughter)

(Address) 506 N. Gilmor St.

15- APR 20 1922 Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 5 1922, to April 19 1922, that I saw her alive on April 19 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Senile Dementia

(Duration) ....yrs. 1 mos. 14 ds.

(Signed) Jos. Harper M. D.

4/18, 1922. (Address) 513 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Apr. 21, 1922

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Eutaw St.

important. See instructions on back of certificate.

Acute Nephritis, due to hard work
Not Lues

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant; Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63622

CERTIFICATE OF DEATH.

D 63622

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Greenwillow ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Musco Russell Garnett

(Residence in Baltimore: No. 609 Greenwillow Ave St.; 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1897 (Year)

7-AGE, 24 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 040
(a) Trade, profession, or particular kind of work: Paper Hanger
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Musco Garnett

(Address) 609 Greenwillow

15- Filed APR 2 01922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 19th 1922, to Apr 19th 1922, that I saw h[illegible] alive on Apr 19th 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease
(Mitral incompetency)
Decompensation
..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none known
..... (Duration) yrs. mos. ds.

(Signed) Chas. J. Kellen M. D.

Apr 20, 1922 (Address) 222 W. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, In Woodlawn Cem. DATE OF BURIAL, 4-22, 1922

20-UNDERTAKER George H. Holland ADDRESS 1631 N. Druid Hill

Spec.—1-10-21—M&T—1500 Bks.

Skarda ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63623

CERTIFICATE OF DEATH.

74 001 D 63623

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 S Bouldin ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Skarda

(a) RESIDENCE NO. 804 S. Bouldon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Skarda

6 DATE OF BIRTH (month, day, and year): Bohemia

7 AGE — Years: 77 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Carl Skarda 804 S Bouldin St

15 APR 2 01922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to April 19, 1922, that I last saw h e alive on April 19, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 6 mos. 16 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis (duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wilmer H. Jameson M. D.

April 19 1922 (Address) 1431 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Apr 22 1922

20 UNDERTAKER: Carl Eversberg — ADDRESS: 1906 Eutaw Pl

mation should be entered, ... CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63624

D 63624

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Hillman ST., 10 WARD)

2-FULL NAME Infr

(a) RESIDENCE NO. 1017 Hillman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ..... Ohd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto city (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER Beulah Trimble

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Mrs Petrie (Address) 1017 Hillman, Roberta

15 APR 20 1922 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19 19 22

17 I HEREBY CERTIFY, That I attended deceased from 4-19, 1922, to 4-19, 1922, that I last saw h alive on 4-19, 1922, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth - 5 mo

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W W Edmondson, M. D.

(Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL

DATE OF BURIAL APR 20 1922

20 UNDERTAKER

ADDRESS

mation should be given in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

D 63625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63625

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 S. East Ave. ST., 26 WARD)

2-FULL NAME Geo. E. M. Schaech

(a) RESIDENCE NO. 709 S. East Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7- 1895.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) 647

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John D. Schaech

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Agatha Zeis

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant John D. Schaech
(Address) 709 S. East Ave.

15 Robt P. Harrison, 19 Registrar

PR 20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1922, to April 18, 1922

that I last saw h alive on April 17, 1922

and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W J McAvoy M. D.

4/20, 1922 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	April 21 1922
20 UNDERTAKER Tilly & Zeiler	ADDRESS 403 S. Mo[illegible]

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63626

CERTIFICATE OF DEATH.

REGISTERED NO. C 57

D 63626

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 W Franklin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa R Pietsch

(Residence in Baltimore: No. 526 W Franklin St.; 73 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Aug 15th (Month) (Day), 1858 (Year)

7-AGE 73 yrs. 8 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... Housework

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Sebastian Sutter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Pietsch

(Address) 526 W. Franklin

15-

Filed APR 20 1922

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 19 1921, to April 19 1922, that I saw her alive on April 19 1922, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) August Horn M. D.

April 19, 1922 (Address) 410 E 23rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, 4/21, 1922

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 63627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63627

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 113 W Belvedere Ave (WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Rontgen

(a) RESIDENCE No. 113 W Belvedere Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Widow of Conrad Rontgen

6 DATE OF BIRTH (month, day, and year): March 10 1861

7 AGE: Years 60 Months 1 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Abendschein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Reiche

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Louisa A Rontgen Pikesville Md

15 Filed 19 Robert F. Carrion, Registrar

Deputy Chief Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1922, to Apr 19, 1922.

that I last saw h alive on Apr 19-22, 19

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast with general metastisis thoracic duct only.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 1921

Was there an autopsy? no

What test confirmed diagnosis? Pathologic exam

(Signed) EE Nichols, M. D.

4-20 1922 (Address) Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leadenhall Park — DATE OF BURIAL: April 23 22

20 UNDERTAKER: William Cahoon & Nathan — ADDRESS

mation should be carefully supplied. Name
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

320 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63628

CERTIFICATE OF DEATH.

49 D 63628

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Towson ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph S. Oliver

(a) RESIDENCE No. 1306 Towson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Oliver

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65,			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Oliver

(Address) 1306 Towson St

15 F[illegible] APR 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/ 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921 to April 20, 1922

that I last saw him alive on April 19- 1922

and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver & Gut Metastasis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Incision

(Signed) A. O'M. Dayton, M. D.

, 19 (Address) 827 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL Apl 22 1922

20 UNDERTAKER Wm Cook ADDRESS 502 E Monta

mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE [illegible] TION is very important. See instructions on back of certificates.

Dr Dayton 827 N Charles St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63629

CERTIFICATE OF DEATH.

57 D 63629

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 N Ensor ST., 10 WARD)

2-FULL NAME Carrie A Hamlin

(a) RESIDENCE NO. 1115 N Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Hamlin

6 DATE OF BIRTH (month, day, and year) Dec 2 1863

7 AGE: Years 58; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Michael Clayman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Rebecca Jane Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Elizabeth Burger

(Address) 1115 N Ensor

15 Filed APR 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922 to April 18, 1922.

that I last saw him alive on April 15, 1922

and that death occurred, on the date stated above, at 8:40 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Jones Jr. M. D.

, 1922 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL April 21 1922

20 UNDERTAKER Wm Cook — ADDRESS N Ave

N. B. ... should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT ... TION is very important. See instructions on back of certificates.

D 63630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63630

CERTIFICATE OF DEATH.

170

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 526 n Patterson Pk ave ST. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Smith.

(Residence in Baltimore: No. 526 n Patterson Pk ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6-DATE OF BIRTH, April 28, 1887
(Month) (Day) (Year)

7-AGE, 34 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Hammerfl
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER Herman Bakerall

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elsa Zickbil

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsa Bakerall.

(Address) 524 n Pat Pk

15-APR 21 1922 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide by Pistol Shot

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) H. Ward Jones M. D.
(Coroner.)

4-15..., 1922 (Address) 4 E. Lex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, First Evangelical Cemetery

DATE OF BURIAL, April 21, 1922

20-UNDERTAKER H. Vanderwende Sons

ADDRESS 1710 Eutaw St.

N.B.—Every item of information should be carefully supplied. Particular attention is called to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63631

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 St. Mc Henry ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Rehm

(a) RESIDENCE. NO. 2515 St. Mc Henry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Rehm

6 DATE OF BIRTH (month, day, and year) Aug. 4-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener 186

(b) General nature of industry, business, or establishment in which employed (or employer) Cemetery

(c) Name of employer London Park Cemetery

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John M. Rehm,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Elis. F. Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Catherine Rehm, (Address) 2515 St. Mc Henry St.

15 Filed APR 21 1922 Registrar

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1921, to April 20, 1922, that I last saw h alive on April 19, 1922, and that death occurred, on the date stated above, at 9:40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ben Owaleey, M. D.

4/21/22 (Address) 4000 Poyson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Apl. 24 1922

20 UNDERTAKER: Elmer W. Conklin

ADDRESS 1248 Eager St.

mation should be given in these terms, so that it may be properly CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

63632

HEALTH DEPARTMENT—CITY OF BALTIMORE

63632

CERTIFICATE OF DEATH.

REGISTERED NO. C 5-74

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Church Home. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary N. King.

(Residence in Baltimore: No. 303 n. Eden. St.; yrs.. 48 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 48 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: James Gibson

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarance King

(Address) 303 N. Eden st

15 APR 21 1922 ROBERT R. KRAUTER, Registrar.

Filed....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) A. Reed Hawkins M. D. (Coroner)

4-19-22, 191..2 (Address) 24 E. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, April 20 1922

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument st

N.B.—Every item of information should be given. Exact statements should be made and properly classified. Exact information is important, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63633

CERTIFICATE OF DEATH.

15-9-002

D 63633

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 N. Carrollton ave. ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Female Infant of Amelia & Earl Hall

(Residence in Baltimore: No. 1148 N. Carrollton ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Apr 17th, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Earl Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Amelia Colbert

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Hall

(Address) 1148 N. Carrollton Ave

15- Filed APR 21 1922 ROBERT P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 18th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 17th 1922, to Apr 18th 1922, that I saw her alive on Apr 18th 1922, and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Failure, Closure of
Foramen Ovale
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ....yrs. 7 mos. ....ds.

(Signed) Harry F. Brown M. D.

Apr 18, 1922 (Address) 1501 Presstman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, Apr. 21, 1922.

20-UNDERTAKER Edward Ruggold

ADDRESS 1463 Carey St

N. B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63634
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D 63634
REGISTERED NO.

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. David Rabinowitz

(a) RESIDENCE. NO. 205 albemarle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rer. 61
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS
10 NAME OF FATHER Isaac Robinowitz
11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant E. Schecter
(Address) 911 Ann St

15 FILED APR 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/22 19

17 I HEREBY CERTIFY, That I attended deceased from 4/19/22, 19, to 4/20/22, 19, that I last saw h. alive on 4/20/22, 19, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilatation

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) H. Feinberg M. D.
4/20, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	4/21. 1922
20 UNDERTAKER	ADDRESS 1127 E. Baltimore
Max Levinson	

Information should be carefully supplied. Answer each question. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63635 HEALTH DEPARTMENT—CITY OF BALTIMORE

38

D 63635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2713 Tivoly ST., 9 WARD)

2-FULL NAME William J. Himmel

(a) RESIDENCE NO. 2713 Tivoly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 4 1883

7 AGE — Years: 38 — Months: 7 — Days: 15 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: National Stamping Co

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wolf Himmel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Doff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Margaret C. Himmel (Address) 2713 Tivoly Ave

15 Filed APR 21 1922 19.. H. M. Lynn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from December 16th 1921 to April 19th 1922

that I last saw him alive on April 18th 1922

and that death occurred, on the date stated above, at 3 45 p. m.

The CAUSE OF DEATH* was as follows:

Dementia Paralytica

(duration) — yrs. 4 mos. 3 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wassermann Reaction in Spinal fluid & Blood

(Signed) Harry Heibel, M. D.

(Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Apr 22 1922
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 Pac

N. B.—WRITE PLAINLY, WITH ... mation should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lucie

Spec.—1-10-21—M&T—1500 Bks.

D 63636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 63636

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 S. Broadway ST. 2 WARD)

2-FULL NAME Mamie Kieser

(a) RESIDENCE NO. 1333 S. Broadway ST., 2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Kieser

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 58 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto. Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Thos. S. Evans & Son 11 N. Royal ave

15 Filed APR 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1922 to April 20 1922 that I last saw her alive on April 19th 1922 and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M J McAvoy M. D.

4/20 1922 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4/24/22

UNDERTAKER: Chas S. Evans & Son

ADDRESS: 11 N. Royal ave

N. B.—Answers to questions should be carefully supplied. AGE should be stated in years, and fraction of a year in months, days, hours or minutes, as the information should be properly classified. Exact statement of occupation is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63637

CERTIFICATE OF DEATH.

X41 D 63637

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

2-FULL NAME William Kelly.

(a) RESIDENCE NO. Deals Island Md. ST., WARD Deals Island Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Beatt Kelly.

6 DATE OF BIRTH (month, day, and year) May 10 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Carrier

(b) General nature of Industry, business, or establishment in which employed (or employer) U.S.

(c) Name of employer

9 BIRTHPLACE (city or town) Deals Island
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Kelly

11 BIRTHPLACE OF FATHER (city or town) Deals Island
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Webster

13 BIRTHPLACE OF MOTHER (city or town) Deals Island
(State or country) Maryland

14 Informant Hospital Record
(Address)

15 APR 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 20, 1922, that I last saw him alive on April 20, 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Right Leg.
Septicemia.

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Toxemia or Cardiac Failure (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Deals Island. Md.

Did an operation precede death? Yes Date of April 12 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Mitchell, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deals Island Md

DATE OF BURIAL 4-22-1922

20 UNDERTAKER E B Harle

ADDRESS 115 E N 3rd St

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 63638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002
D 63638

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen. Hospital. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard. Le Roy. Boan.

(a) RESIDENCE. No. 1415 Andre st. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jos. D. Boan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama.

12 MAIDEN NAME OF MOTHER Elizabeth Endlich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

11 Informant Joseph D Boan
(Address) 1415 Andre St

15 APR 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4- 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Apl. 20. 1922 to Apl. 20 1922, that I last saw h alive on Apl. 20. 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 2 hrs

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Herbert C Blake M. D.

, 19 (Address) 1014 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Swartz. Crem	4- 22 1922
20 UNDERTAKER	ADDRESS
E B Stark	115 E West St

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63639 **CERTIFICATE OF DEATH.** 31 D 63639

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gage S. Williams

(Residence in Baltimore: No. 231 Parish St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 52 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)..... Construction work.

9-BIRTHPLACE, (State or Country) South Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed APR 21 1922, 191..... ROBERT R. KRAUTER, Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 13 1922, to April 19 1922, that I saw him alive on April 19 1922, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

1 Myocardial Insufficiency

Lobar pneumonia

(Duration)....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 5 yrs.....mos.....ds.

(Signed) J. C. Magruder M. D.

April 19, 1922 (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ... DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health. ADDRESS APR 21 1922

For Wm. E. [illegible]

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63640

CERTIFICATE OF DEATH.

161-00 D 63640

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 112 N. Calhoun ST.; West End Maternity Hosp WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Mayhew West End Maternity Hosp.

(Residence in Baltimore: No. 1802 Linden Ave (mother) St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	W.	Baby

6-DATE OF BIRTH. April 20, 1922
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.
If LESS than 1 day, 5 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. md

PARENTS.

10-NAME OF FATHER, Wm. Mayhew

11-BIRTHPLACE OF FATHER (State or Country), York Pa.

12-MAIDEN NAME OF MOTHER Thelma Ruth Craig

13-BIRTHPLACE OF MOTHER (State or Country), Nanticoke Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Stromberger R. N.
West End Maternity Hosp
(Address) 112 n. Calhoun St.

15- Filed APR 21 1922, 19... ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20 1922, to April 20 1922, that I saw h[illegible] alive on April 20 1922, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth

5 hrs
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Asbury Dailey M. D.

(Address) April 20, 1922 1611 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 6 hrs ds. In the State ..... yrs. ..... mos. 5 hrs ds.

Where was disease contracted, if not at place of death? premature Birth

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL
DATE OF BURIAL, APR 21 1922, 19...

20-UNDERTAKER .....
ADDRESS .....

Commissioner of Health.

N. B.—Every item of information should be carefully supplied. Exact statement of occupation may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

19129

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63641

CERTIFICATE OF DEATH.

113 D 63641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4324 E. Lombard ST., WARD 26

2-FULL NAME Elizabeth L Klingler

(a) RESIDENCE NO. 4324 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER William B Klingler

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret L. Foy

13 BIRTHPLACE OF MOTHER (city or town) Danville (State or country) Pa.

14 Informant William B Klingler (Address) 4324 E Lombard St

15 APR 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to April 20, 1922, that I last saw her alive on April 20, 1922, and that death occurred, on the date stated above, at 4 10 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maxwell Mayer M. D.

Apl. 19 22 (Address) 3115 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cmetry DATE OF BURIAL April 22 1922

20 UNDERTAKER John F Denny. ADDRESS 715 Light St

D 63642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63642

CERTIFICATE OF DEATH.

REGISTERED No. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1601 N Port St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip J. Dash.

(Residence in Baltimore: No. 1601 N Port St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 13, 1850
(Month) (Day) (Year)

7-AGE, 72 yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Dash

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Mary Kinn

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa B. Dash

(Address) 1601 N. Port st

15-

Filed APR 21 1922 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. Krauter Tuesday M. D.
(Coroner)

4-7-7, 1917. (Address) 29 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, April 23, 1922

20-UNDERTAKER John F. Denny — ADDRESS 715 Light st

N. B.—Every item of information should be carefully supplied. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63643

CERTIFICATE OF DEATH

79D 63643

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 864 W. Fayette St. 18 WARD) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Friedricka Forast.

(Residence in Baltimore: No. 864 W. Fayette St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow.

6-DATE OF BIRTH: ..... (Month) January (Day) 1 (Year) .....

7-AGE: 72 yrs. mos. ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Widow
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE (State or country): Balto.

PARENTS

10-NAME OF FATHER: Not known.

11-BIRTHPLACE OF FATHER (State or country): Not known.

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (State or country): Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Conner.

(Address) 864 W. Fayette.

15.

Filed APR 21 1922 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 20 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 20 1922, that I saw h- alive on April 20 - 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

Indefinite (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Indefinite.

— (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry F. Arthur M. D.

Apr. 21, 1922 (Address) 1426 Mansfield

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Schwartz | DATE OF BURIAL: 4/21/22. 191

20-UNDERTAKER: Wm. Cook | ADDRESS: 502 E. Nath ave.

N. B.-Every item of information should be carefully supplied. AGE should be stated in YEARS. If LESS than 1 year, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

D 63644

CERTIFICATE OF DEATH.

D 63644

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 5418 Magnolia St., (WARD) 22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma M. Johnston

(a) RESIDENCE NO. 5418 Magnolia St., WARD 22

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rosina Magner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. L. Johnston

(Address) 5418 Magnolia ave

15 APR 21 1922 ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1922 to April 19, 1922,

that I last saw h[illegible] alive on April 19, 1922,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal

(Signed) Emma Jones, M. D.

19 (Address) 2802 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr 22 1922
20 UNDERTAKER Robt. Jenner	ADDRESS N. Ave

mation should be entered, as given, so that it may be properly classified.
CAUSE OF DEATH in plain terms. so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63645

CERTIFICATE OF DEATH.

1003
159
D 63645

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Mairs

(Residence in Baltimore: No. 2006 E Lafayette Ave St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, 4 (Month) / 16 (Day), 1922 (Year)

7-AGE, ...yrs. .....mos. 4 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry F Mairs

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Delaney Clark

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Mairs

(Address) 2006 E Lafayette Ave

15- APR 21 1922 191.. ROBERT RIEMANN, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) / 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/16/1922, to 4/20/1922, that I saw him alive on 4/20/1922, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Congenital Stenosis Pylorus

(Duration) ...yrs. ...mos. 4 ds.

(Signed) Albert F. Fitzgerald M. D.

....., 191... (Address) 1613 E Fayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, April 22, 1922

20-UNDERTAKER Pohl & Turner Inc

ADDRESS 1442 W Broadway

N.B.—Every item of information CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63646

CERTIFICATE OF DEATH.

45 D 63646

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 Guilford Ave. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Cochran

(a) RESIDENCE. NO. 2631 Guilford Ave. ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, ~~widowed, or divorced~~ — HUSBAND of ~~XXXXXXXX~~ Augusta Cochran

6 DATE OF BIRTH (month, day, and year) Dec. 14. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER John Cochran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Augusta Cochran 2631 Guilford Ave

15 Filed Apl 21, 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 20. 1922 19

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922 to Apr 20, 1922, that I last saw him alive on Apr 20, 1922 and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Cancer of intestines

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm S Watson, M. D.

(Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Staten Island. N.Y.	Apl. 22. 19 22
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

MAKE ENTRIES OF DEATH in plain terms, so that it may be properly CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

R 21 1922

D 63647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63647

CERTIFICATE OF DEATH.

X 188-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Marks

(Residence in Baltimore: No. S. Bolton Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colrd	Sngle

6-DATE OF BIRTH, ... Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE, 22 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION;
(a) Trade, profession, or particular kind of work..... Laborr 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country). " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Coronrs Records

(Address).....

15- Robert F. Harrison, 191.....
Registrar.

Burial Permit Clerk

NOV 21 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April ..... 15 ....., 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Haemorrage & Hematoma Stroke

(Duration) .....yrs. .....mos. .....dys.

CONTRIBUTORY (Secondary) Rupt Duo. & Bro. Bl. Bowel

(Duration) .....yrs. .....mos. .....ds.

(Signed) W. F. Gonnerd M. D.
(Coroner.)

4-21, 1922 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND. DATE OF BURIAL, NOV 25 1922

20-UNDERTAKER [redacted] Health, ADDRESS

Per. Wm. F. [redacted]

Every item of information should be given as accurately as possible, so that it may be properly classified. Exact information in regard to CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63648

D 63648

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger E. Gentz

(a) RESIDENCE. NO. Arcadia Balto Co. ST. WARD Arcadia, Balto. Co. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White American	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	11	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Roger E. Gentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Roger R Gentz Arcadia Md

15 Filed Robert F. Harrison, Registrar

APR 21 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 21, 1922, that I last saw him alive on April 21, 1922, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Appendicitis, acute, ruptured, with appendicular and subdiaphragmatic abscess.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 20, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H B Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel Carroll Co.	April 23 1922
20 UNDERTAKER Wm Fickus Sons	ADDRESS Westminster Md

CAUSE OF DEATH in plain terms, so that it may be classified. Physicians are required to report to the Health Department within 24 hours after death the cause of death of every person whose death they certify. Any physician who refuses or neglects to make such report shall be guilty of a misdemeanor and subject to a fine of not more than $100.00 for each offense. See back of certificates.
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63649

CERTIFICATE OF DEATH.

D 63649

74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sisters of the Poor; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johnn Dougherty.

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Dougherty

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Andrew Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McKenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence, (Address) Preston & Valley

15 Filed April 21 1922 Robert F. [illegible] Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from to record, 19 to , 19 , that I last saw h in alive on April 16, 1922, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

, 1922 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 22 1922
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Ave

mation should be carefully supplied, so that it may be properly classified. Cause of death may be CAUSE OF DEATH in plain terms, so that it may be properly classified. Cause of death may be TION is very important. See instructions on back of certificates.

R 21 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63650

CERTIFICATE OF DEATH.

90

D 63650

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Overlea Aver Oak ST., Averlea (WARD)

2-FULL NAME Charles Harman Harman

(a) RESIDENCE NO. Overlea Ave. & Oak ST., Averlea WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Harman

6 DATE OF BIRTH (month, day, and year) Aug 8th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore (Master)

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary E. Hemsley (Address) 1601 N. Broadway

15 Filed ....., 19.... Robert P. Harrison, Registrar

R21 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 18 1922 to Apr 20 1922

that I last saw h alive on Apr 19 1922

and that death occurred, on the date stated above, at 2 30 a.m.

The CAUSE OF DEATH* was as follows:

Cordiac Mastenia or Dilatation

(duration) 1 yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Phys. Surgeon

What test confirmed diagnosis? .....

(Signed) N. Hutchinson, M. D.

, 19 (Address) 1340 O'Donnell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 22 1922
20 UNDERTAKER	ADDRESS
Fred'k Lussenheimer Sons	Baltimore Md

Information should be carefully supplied. Accurate answers to questions CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63651

D 63651

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1831 (Light) ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. McLaughlin

(a) RESIDENCE NO. 1831 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced: (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 25 1895

7 AGE: Years 27 Months 2 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Luke McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Casey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine McLaughlin (Address) 1831 Light St.

15 Filed Robert P. Harrison, Registrar

R 21 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 22

17 I HEREBY CERTIFY, That I attended deceased from Jan, 19 22, to April 19 19 22.

that I last saw h alive on April 17, 19 22

and that death occurred, on the date stated above, at 7-50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Months yrs. mos ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signed H. E. Campbell M. D.

Apr 22, 19 22 (Address) 1644 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: April 22 19 22

20 UNDERTAKER: Margaret E. Flynn

ADDRESS: 1422 Light St.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63652

CERTIFICATE OF DEATH.

D 63652

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Gough ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carmon G. Rotondo

(a) RESIDENCE. No. 1217 Gough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Salvatora Rotondo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Rinaldo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant: Salvatora Rotondo
(Address) 1217 Gough

15 Filed Robert P. Harrison, Registrar

PR 22 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 20, 1922, that I last saw h[illegible] alive on April 20, 1922, and that death occurred, on the date stated above, at 3 [illegible] m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? /

What test confirmed diagnosis?

(Signed) [signature] M. D.

April 21, 1922 (Address) 1217 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	April 1922
20 UNDERTAKER	ADDRESS
Wendell Diffenbaugh	3781 Fm

mation should be carefully [illegible] CAUSE OF DEATH in plain terms, so that it may be properly [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

✓ OK, H K Gonsch

D 63653 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63653

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital X 185 REGISTERED NO.

CITY OF BALTIMORE: (No. Fawcett & Green ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan A Gardner

(a) RESIDENCE. NO. Jessup's M d. WARD. Jessups Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a If married, widowed, or divorced (or) WIFE of Wilbur F Gardner

6 DATE OF BIRTH (month, day, and year) 4-25 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 680

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Silson Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Annie J Hawkins
(Address) Cambridge Md.

15 Filed APR 22 1922, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21, 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-12, 1922 to 4-21, 1922 that I last saw her alive on 4-21, 1922 and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

over

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Intertrochanteric fracture of right hip (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Clinical finding

What test confirmed diagnosis?

(Signed) H Wilder M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jessup Md	Apr 23 1922
20 UNDERTAKER Wm Fickus Sons	ADDRESS Norfolk Va

D 63654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63654

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3502 Fairview Ave St.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marshall E. Reddick

(Residence in Baltimore: No. 4300 Maine Ave St.; 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 21, 1867 (Month) (Day) (Year)

7-AGE, 54 yrs. 10 mos. 0 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Superin Apartments
(b) General nature of industry, business, or establishment in which employed (or employer) G R Morris

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Reddick

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Dk

13-BIRTHPLACE OF MOTHER (State or Country), Dk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Stella R Reddick

(Address) 4200 Maine Ave

15- Filed APR 22 1922, 191.....

Robert F. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

April 24 1922 (Address) 2502 Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	April 24, 1922
20-UNDERTAKER	ADDRESS
Wm J Luckner Son	North Ave

Every item of information should be given, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63655

CERTIFICATE OF DEATH.

D 63655

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Romana Mattingly

(a) RESIDENCE NO. St. Agnes Hospital WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Aug 6 1850

7 AGE: Years 71 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nun 018

(b) General nature of industry, business, or establishment in which employed (or employer): Priest

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Lyster Mattingly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen Hogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Sister Mattingly St Agnes Hosp

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

R 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1921, to April 19, 1922 that I last saw him alive on April 19, 1922 and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pharynx

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) WC Baldwin, M. D.

April 19 22 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem DATE OF BURIAL: April 22 1922

20 UNDERTAKER: John F Lawrence ADDRESS: 1318 Light

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 63656

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1799 D 63656

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 863 June ST. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Gertrude Howard

(Residence in Baltimore: No. 863 June St.: 48 yrs. 3 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: January (Month) 3 (Day) 1874 (Year)

7 AGE: 48 yrs. 3 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Domestic 070
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Alexander Price

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lida Thomas

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alice Thomas

(Address) 863 June St

15 Filed APR 2 1922, 191.. Robert L. Bartlett, Clerk, Burial Permit Clerk. REGISTRAR

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 19 (Day) 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1922, to April 18 1922, that I saw h.. alive on April 18, 1922, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

Coma

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Parenchymatous Nephritis

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) W. T. Sellers M. D.

April 21, 1922 (Address) 932 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: April 22, 1922

20 UNDERTAKER: Chas H Hooper

ADDRESS: 406 W Pratt

D 63657

D 63657

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1228 S Decker Ave ST.: 1 WARD)

2-FULL NAME Dovotha Slowianozyk

(a) RESIDENCE. NO. 1228 S Decker Ave ST.: 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 16-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Peter Slowianozyk

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Golembieska

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Peter Slowianozyk
(Address) 1228 S Decker Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to April 21st, 1922, that I last saw h[illegible] alive on April 21, 1922, and that death occurred, on the date stated above, at 11 45 p.m.

The CAUSE OF DEATH* was as follows:

gastro enteritis, subacute
Intestinal —
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) eclampsia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. W. Wright, M. D.

7/22, 1922 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	April 23 1922
20 UNDERTAKER	ADDRESS
Hirko & Frankowski	[illegible]

B.—WRITE PLAINLY. Words must be fully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be caref

Spec.--1-10-21--M&T--1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63658

D 63658

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2604 Fredrick ST., 22nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Wm C H Keyser

(a) RESIDENCE NO. 2604 Fred Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lina Keyser

6 DATE OF BIRTH (month, day, and year) Sept 13, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Veternary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lina Keyser

(Address) 2604 Fred Ave

15 Filed APR 22 1922 H Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to April 21, 1922.

that I last saw him alive on April 21, 1922,

and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arterio-sclerosis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

April 22 1922 (Address) 2687 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL April 24 1922

20 UNDERTAKER Geo. W. Little

ADDRESS 27 N Edmondson Ave

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Stmc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63659

CERTIFICATE OF DEATH.

D 63659

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 647 N Paca St ST.: 22 WARD)

2-FULL NAME John Wilson Gambrill

(a) RESIDENCE. NO. 647 N Paca St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katie J Gambrill

6 DATE OF BIRTH (month, day, and year) Sept 21 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	6	—	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Hand Boot Factory

(c) Name of employer Bacher Bros

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas Wilson Gambrill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louisa Bruson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Katie J Gambrill (Address) 647 N Paca St

15 Filed APR 24 1922 19 J H Adm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1922

17 I HEREBY CERTIFY, That I attended deceased from Apl 7th, 1922, to apl 20, 1922, that I last saw him alive on apl 19, 1922, and that death occurred, on the date stated above, at 1245P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Gustav Goldman, M. D.

19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Apl 23 1922

20 UNDERTAKER: David Eastoni — ADDRESS: 916 Paca

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63660 ✓ D 63660

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Previtte

(a) RESIDENCE. No. 1011 W. Starling Court ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Samuel Belmonti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Vincenze Crisstofa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Hospital Records M.T.H.

15 Filed APR 22 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from January 27, 1922, to April 21, 1922.

that I last saw h alive on , 19 .

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglisch M.D.

4-21-22 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Vincent Cem

DATE OF BURIAL June 24 1922

20 UNDERTAKER GEORGE M. FINK, FUNERAL DIRECTOR.

ADDRESS 811 N. Eutaw St.

mation should be certain, definite terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 63661

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1304 N. Luzerne St (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walter Wilson

(a) RESIDENCE NO. 1304 N. Luzerne st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G. Wilson

6 DATE OF BIRTH (month, day, and year) 11/4/1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 004

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary A Keenan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry Wilson

(Address) 1304 N. Luzerne St

15 APR 22 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21 1922

17 I HEREBY CERTIFY, That I attended deceased from April, 1922, to April 21, 1922.

that I last saw him alive on April 20, 1922.

and that death occurred, on the date stated above, at 3-10 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tumor Lung

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Phthisis Pulmonalis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) Harry C Agnew, M. D.

, 19 (Address) 3640 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 4/24 1922

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

mation should be carefully supplied. Blanks must be properly classified. Data CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63662

CERTIFICATE OF DEATH.

32

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Druid Hill Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Lodan

(a) RESIDENCE. No. 1721 Druid Hill Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29 1904

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Lodan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Irene Lodan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Father) Thomas Lodan 1721 Druid Hill Ave

15 Filed APR 22 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22 1922

17 I HEREBY CERTIFY, That I attended deceased from April 18th 1922, to April 21st 1922, that I last saw h alive on April 20th 1922, and that death occurred, on the date stated above, at 5 AM m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Ex Lanation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/22/19 (Signed) Benj Ortcheny, M. D.

(Address) 400 N Pays St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shark Street

DATE OF BURIAL April 23 1922

20 UNDERTAKER Charles H Alexander

ADDRESS 721 N Eutaw St

mation should be carefully written in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63663

CERTIFICATE OF DEATH.

74-001 D 63663

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Jefferson ST., 6 WARD)

2-FULL NAME John Forman Solomon

(a) RESIDENCE NO. 1704 Jefferson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	77	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired DOD

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William J. Solomon

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Wilds

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Mary E Solomon
(Address) 1704 Jefferson St

15 Filed APR 22 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1 1922 to April 21 1922, that I last saw him alive on April 20 1922, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jed D Towning, M. D.

April 21 1922 (Address) 1107 Lexington Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gallenmount Cemetery

DATE OF BURIAL April 24 1922

20 UNDERTAKER George D Schilling & Sons

ADDRESS 1126 E Monument St

N. B.—WRITE plainly. All information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

See Statement Over

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63664

D 63664

CERTIFICATE OF DEATH.

90

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 405 Dover St. ST. 22 WARD)

2 FULL NAME ~~Joseph~~ Joshua Wallace

(Residence in Baltimore) No. 405 Dover st

St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, Dont Know (Month) (Day), 1881 (Year)

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Josh Wallace

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Lonnie Smith

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet A. Watkins

(Address) 312 Lemon St

15- Robert F. Harrison,

APR 22 1922, 191

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy~~ or inquiry.) thereon and from the evidence obtained by said (Inquest, ~~autopsy~~ or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Saturday Disease of the Heart

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

4-22, 1922. (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon Cem. DATE OF BURIAL, Apr 24 1922

20-UNDERTAKER, Lemuel Hemsley ADDRESS Madison

NB Every item of information should be given so that it may be properly classified. Read statement on CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

REG. No. 1776
PHONE CALVERT 2650

DR. H. K. GORSUCH
117 W. SARATOGA STREET
OFFICE HOURS: 9 TO 12 A. M., 3 TO 5 AND 7.30 TO 9 P. M.
SUNDAYS, 9 TO 11 A. M. ONLY

PATIENT'S NAME

ADDRESS

℞

S. E. 22-

The Rev. F. Joshua Wallace
should have been written
his death certificate
written F. Joseph Wallace

Attorney at
Cor. Md

SPETZLER DRUG CO.
RELIABLE PHARMACISTS
H. C. SPETZLER FRED W. FINK
123 W. Baltimore St., Cor. Hopkins Place, Baltimore

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease: Chronic interstitial nephritis,* etc. The con-ercurrent) affection need :ant. Example: *Measles* 29 *ds.; Broncho-pneu-s.* Never report mere nditions, such as "As-ely symptomatic), "At-a," "Convulsions," "De-enile," etc.), "Dropsy," ilure," "Hæmorrhage," "Old Age," "Shock," tc., when a definite dis-as the cause. Always ng from child birth or *septichæmia,*" "PUERP-tc cause for which sur-ertaken. For VIOLENT INJURY and qualify as MICIDAL, or as *probably* termine definitely. Ex-*ing; Struck by railway wound of head—homi-acid—probably suicide.* as fracture of skull, and *tetanus*) may be stated ry."

rned for additional in-e any of the following on as the sole cause of

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gangrene, Gastritis, Erysipelas, Meningitis, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Blks.

D 63665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 63665

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1728 Lancaster (St.,) V (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Kosmicky.

(a) RESIDENCE NO. 1729 Lancaster ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sep 21-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	7.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Philip Kosmicky.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Chlopicky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Kosmicky.

(Address) 1729 Lancaster

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21— 1922

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1922, to April 21, 1922,

that I last saw h— alive on April 21, 1922,

and that death occurred, on the date stated above, at 8 p.— m.

The CAUSE OF DEATH* was as follows:

Diphtheria - (Throat)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Contracture paralysis

(duration) yrs. mos. Saved

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Thos. O'Donnell, M. D.

, 19 (Address) 125 E Biddle —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary.

DATE OF BURIAL 4/22 1922

20 UNDERTAKER William Gallagher 1618 Eastern Ave

ADDRESS

4 22 1922

Brester.

mation should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63666

CERTIFICATE OF DEATH.

31

REGISTERED NO. 6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Daniels

(a) RESIDENCE. NO. 1517 Fairmont ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer (Odd)

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Jacob Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address) Hospital Records M.T.H.

15 Filed APR 24 1922, 19 Robert T. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11th, 1922, to April 19, 1922, that I last saw him alive on April 19, 1922, and that death occurred, on the date stated above, at 8.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L Dadaglaced M. D

4-11, 22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: APR 22 1922

20 UNDERTAKER: Commissioner Health.

ADDRESS

mation should be carefully written, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63667

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda (Amelia) Johnson

(a) RESIDENCE. NO. Melvale School ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Live yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

100

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

15 Filed 19 Robert P. Harrison, Registrar
1922 1913 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to April 19, 1922, that I last saw h alive on April 19, 1922, and that death occurred, on the date stated above, at 5.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) Francis L. Badaglucco M. D.

4-20-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL APR 22 1922 19

20 UNDERTAKER (Commissioner Health.) ADDRESS

mation should be carefully made, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

139
R2

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63668

CERTIFICATE OF DEATH.

31

D 63668

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman T. Vnoop

(a) RESIDENCE. No. 724 S. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Vnoop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records
(Address) M.T.H.

15 Filed 1922 Robert T. Garrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to April 22, 1922, that I last saw him alive on April 22, 1922, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dadoyliacca, M.D.

4-22-1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 4/22/22 1922

20 UNDERTAKER: Wm. Cook.

ADDRESS: 502 E. Nott

mation should be entered, CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

R 22 1922

Spec.—1-10-21—M&T—1500 Bks.

B & O. R R V

D 63669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63669

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 25 WARD)

2-FULL NAME Mrs Mary J. De Bolt.

(a) RESIDENCE NO. Pine Grove W. Va ST., ... WARD Pine Grove W. Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm De Bolt

6 DATE OF BIRTH (month, day, and year) Mar 22 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61 yrs	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10 NAME OF FATHER Do not know James Jolliffe

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Pine Grove W Va

12 MAIDEN NAME OF MOTHER Ruth Long

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Pine Grove W. Va

14 Informant Mrs. Geo. Weaver
(Address) Fort Worth Texas

15 Filed ....., 19.... Registrar

APR 2 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21- 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-4, 1922, to 4-21, 1922.

that I last saw h alive on 4-21, 1922

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

.....

.....

.....

.....(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Acute Dilatation of the Heart

.....(duration) ....yrs. ....mos. 6 ....ds.

18 Where was disease contracted if not at place of death? Ft. Worth, Tex.

Did an operation precede death? No Date of 4-20-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. C. Arnold, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL April 24 19 22

20 UNDERTAKER F. B. Pumphrey ADDRESS 2336 Frederick Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Lewin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63670

D 63670

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Lewin

(a) RESIDENCE NO. 115 aisquith street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	93	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper 000

(b) General nature of industry, business, or establishment in which employed (or employer) Aged Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore St

15 APR 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 21, 1922, that I last saw h[illegible] alive on April 21, 1922, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. Baylis, M. D.

4/22 1922 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Ld DATE OF BURIAL 4/23 1922

20 UNDERTAKER Jack Lewis 1439 E Baltimore ADDRESS

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63671

CERTIFICATE OF DEATH.

100-002

D 63671

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellie Caplan

(a) RESIDENCE NO. 115 aisquith street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther caplan

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junkman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Junkman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Junkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1439 Ballst

15 APR 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15 1922, to April 21 1922.

that I last saw him alive on April 21 1922

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Uremia no office

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M J Baylin, M. D.

4/22 1922 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 4/23 1922

20 UNDERTAKER Jack Louis 1439 E Balt St

ADDRESS

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. Every question is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63672

CERTIFICATE OF DEATH.

100,001

D 63672

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 912 N. Carrollton ave ST.: 16 WARD)

2-FULL NAME Sophronie Shultz

(a) RESIDENCE. NO. 912 N. Carrollton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Charles H. Shultz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) - -

(c) Name of employer - -

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Saums

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Charles H. Shultz 912 N. Carrollton Ave

15 APR 23 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 16th, 1922, to Apr 21st, 1922, that I last saw h alive on Apr 20th, 1922, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. R. Lucien, M. D.

, 19 (Address) 614 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL April 24 1922

20 UNDERTAKER Graham H Walker

ADDRESS 733 W Lafayette Ave

MAKE STATEMENTS IN PLAIN TERMS, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 63673

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 63673

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Leadenhall St.; 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Harridy

(Residence in Baltimore: No. 1936 Leadenhall St.; 35 yrs. 11 mos. 4 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. May (Month) 15 (Day), 1886 (Year)

7-AGE. 35 yrs. 11 mos. 4 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Canvasser
(b) General nature of industry, business, or establishment in which employed (or employer). 070

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. James Harridy

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Christina Savoy

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Harridy

(Address) 1936 Leadenhall St

15-

Filed APR 23 1922

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 14 1922, to April 20 1922, that I saw h— alive on April 20 1922, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tbc.

(Duration) 6 yrs. mos. da.

CONTRIBUTORY (Secondary) Tbc Pulmonary

(Duration) yrs. 6 mos. da.

(Signed) J. W. Gibson M. D.

April 21, 1922. (Address) 717 S Mount St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. M-Auburn

DATE OF BURIAL. Apr 23 1922

20-UNDERTAKER Sam'l H. Cleaver & Son

ADDRESS 1400 Madison

CAUSE OF DEATH in plain terms. Every item important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63674

CERTIFICATE OF DEATH.

51 D 63674

D 63674

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1819 E. Pratt ST., W WARD)

2-FULL NAME Rachel Rudit Shapiro

(a) RESIDENCE NO. 1819 E. Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1852

7 AGE: Years 70 | Months — | Days 1 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Russia

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Israel Fishkovitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Wolfson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mrs Anna Margolies 1819 E Pratt St

15 Filed APR 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1922, to April 21st, 1922, that I last saw h[illegible] alive on April 21st, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 9 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs & history

(Signed) Eugene J Leopold, M. D.

4/21 1922 (Address) 503 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew pt Carmel Rd

DATE OF BURIAL 4/23 1922

20 UNDERTAKER M. Hanson

ADDRESS 1127 E. Baltimore St

mation should be carefully supplied, so that it may be properly classified. Particular attention should be given to CAUSE OF DEATH in plain terms

Spec. 6-9-19—H. P. Co.—1000 Rks.

D 63675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63675

X 38

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD.

2-FULL NAME James L. Williams

(a) RESIDENCE. NO. Mount Hope Retreat ST., 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
30	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer for Brown Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Buying (2)

(c) Name of employer Brown Co.

9 BIRTHPLACE (city or town) (State or country) Hartford Conn

PARENTS

10 NAME OF FATHER James F. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Baltimore Md

15 Filed APR 23 1922, 19.. ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 19..

17 I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 19.., to April 22, 19.., that I last saw h[illegible] alive on April 22, 19.., and that death occurred, on the date stated above, at 8.55 P m.

The CAUSE OF DEATH* was as follows:

Paresis - Specific

ccbt (duration) 9 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Melancholia —

Ebr (duration) 9 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Hartford Conn -

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19.. (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hartford Conn

DATE OF BURIAL 4-23 1922

20 UNDERTAKER Harry W Jenkins Sons Co

ADDRESS Allegheny & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAT—1500 Blks.

John Purulewski.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63676

90 D 63676

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1722 Aliceanna ST., 2 WARD)

2-FULL NAME John Purulewski

(a) RESIDENCE NO. 1722 Aliceanna ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. - mos. - ds. How long in U. S., if of foreign birth? 34 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Josephine Purulewski

6 DATE OF BIRTH (month, day, and year) June 15 87

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	54	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Poland
(State or country)

PARENTS

10 NAME OF FATHER Frantz Purulewski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Katherine Kwiecinski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mrs. John Drokowski.
(Address) #1722 Aliceanna St.

15 APR 23 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/18, 1922, to 4/21, 1922,

that I last saw h alive on 4/21, 1922;

and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation &
chronic pulmonary congestion

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia & heart failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) H. A. Kostt, M. D.

, 19 (Address) 1612 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL Apr 24, 1922

20 UNDERTAKER M. F. Sadowski

ADDRESS 705 S. Ann St.

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63677
1-PLACE OF DEATH

34 D 63677
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 4115 Hallz Road ST., 13 WARD)

2-FULL NAME William Bell

(a) RESIDENCE NO. 4115 Hallo Road ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Amanda Bell

6 DATE OF BIRTH (month, day, and year) Oct. 24-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	5	28	

8 OCCUPATION OF DECEASED 946
(a) Trade, profession or particular kind of work Mill Hand
(b) General nature of Industry, business, or establishment in which employed (or employer) Cotton mill
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Maryland

PARENTS
10 NAME OF FATHER Henry Bell
11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)
12 MAIDEN NAME OF MOTHER Martha Rose
13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs. Amanda Bell
(Address) 4115 Hallo Road

15 Filed APR 23 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1922, to April 21, 1922.
that I last saw him alive on April 21, 1922,
and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of 1st Cervical Vertebrae
(duration) unknown yrs. mos ds.
CONTRIBUTORY (Secondary) Post Pharyngeal abscess (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X-Ray examination
(Signed) Walter Dailey, M. D.
, 19 (Address) 1611 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) — DATE OF BURIAL April 24 1922
20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Falls Rd

mation should be carefully ... so that it may be properly classified.
CAUSE OF DEATH in plain terms,
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr C L Smith 817 Park ave

D 63678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63678

31

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Baker ST., 15 WARD)

2-FULL NAME Mary H. Mc. Manus

(a) RESIDENCE NO. 1819 Baker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mc. Manus

6 DATE OF BIRTH (month, day, and year) May 22-1870

7 AGE — Years 51 Months 11 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Muth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie E. Schmidt

(Address) 1819 Baker St

15 APR 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr, 1921, to Apr 21, 1922;

that I last saw her alive on April 19, 1922;

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mel

Pulmonary Tuberculosis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Anthrax

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? no knowledge

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) C Norton Smith, M. D.

, 19 (Address) 817 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn Cemetery

DATE OF BURIAL April 24 19 22

20 UNDERTAKER F. B. Nugent

ADDRESS 2736 Fred'k ave

mation should be carefully supplied, so that it may be properly classified. Exact CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63679 | 31 D 63679 | REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 S. Fulton Ave ST. ..... WARD) 70

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Marckl

(Residence in Baltimore: No. 18 S. Fulton Ave St.; 31 yrs. 10 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 28 (Day), 1890 (Year)

7-AGE, 31 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): DIY

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George D Marckl

11-BIRTHPLACE OF FATHER (State or Country), St Louis Ill

12-MAIDEN NAME OF MOTHER Elizabeth Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Schofield

(Address) 18 S Fulton Ave

15- Filed APR 23 1922 By ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 21 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 3 1922, to April 21 1922, that I saw h[illegible] alive on April 20 1922, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 2 yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dyspnea

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Edwin A Coulston M. D.

April 22 1922 (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	April 24, 1922.
20-UNDERTAKER Harry J Armacost	ADDRESS 4204 Ridgewood Ave

N. B. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63680

CERTIFICATE OF DEATH.

101-001

D 63680

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. a) ST., 10 WARD)

2-FULL NAME Laray, Warthen

(a) RESIDENCE NO. 1010 Lamont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) May 23, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
(11 mo)		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Raymond Warthen

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Kessoth

13 BIRTHPLACE OF MOTHER (city or town) Balt.
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records.

15 Filed APR 23 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-16, 1922, to 4-22, 1922,

that I last saw her alive on 4-22, 1922

and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) TB Gay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 24 19 22
20 UNDERTAKER Turkel & Zirkel	ADDRESS 739 Eager

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63681

CERTIFICATE OF DEATH.

D 63681

164

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Homeland Ave ST.; Govans 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Fjams

(Residence in Baltimore: No. Same 417 Homeland Av St.; 0 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH, May (Month) 2 (Day), 1832 (Year)

7-AGE, 89 yrs. 11 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country) Md U.S.

PARENTS.

10-NAME OF FATHER, Geo. L.

11-BIRTHPLACE OF FATHER (State or Country) Pa U.S.

12-MAIDEN NAME OF MOTHER E. Voght

13-BIRTHPLACE OF MOTHER (State or Country) Pa U.S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A Goodman

(Address) 417 Homeland Ave

15- APR 23 1922 Filed ....., 191... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 21 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~~ 1910, to 4/21/22 191..., that I saw h[er] alive on 4/21/22 191..., and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Old Age.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Wm Gaddes M. D.

4/22/22, 191... (Address) 321 E 25th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, 4/24..., 1922

20-UNDERTAKER David Sondheim — ADDRESS 418 N. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that ... important. See instructions on back of certificate.

Harvell.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63682

CERTIFICATE OF DEATH.

REGISTERED NO. 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen. Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver David Harvell

(a) RESIDENCE. NO. ~~617~~ 439 Grindall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 - 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clarence D. Harvell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Dressell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Clarence Harvell
(Address) 739 Grindall St

15 APR 23 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1921, to April 22, 1922
that I last saw him alive on April 22, 1922,
and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Pyemia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Osteomyelitis of left tibia + Surgical shocks (duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 4/22/22

Was there an autopsy? no

What test confirmed diagnosis? Blood culture { Staphylococcus aureus

(Signed) Joseph Pokorny, M. D.

, 19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Apr 25 1922

20 UNDERTAKER J Herwig & Co

ADDRESS 2008 Eden

MATTER SHOULD BE WRITTEN IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63683

CERTIFICATE OF DEATH.

91-00 D 63683

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1921 Gough St ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lowensen

(a) RESIDENCE. NO. 1921 Gough St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of August Lowensen

6 DATE OF BIRTH (month, day, and year) Nov - 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Siebert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Eliz England

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August Lowensen (Address) 1921 Gough St

15 Filed APR 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922, to April 21, 1922, that I last saw her alive on April 21, 1922, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows: 037

Pneumonia, (hypostatic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis H. Krause M. D

, 19 (Address) 3500 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Apr 25 1922

20 UNDERTAKER J. Herwig & Co

ADDRESS 2008 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCALITY OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral arterio sclerosis. No terminal hemorrhage.

Spec.—1-10-21—M&T—1500 Bks.

D 63684 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

D 63684
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 E Hoffman ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Margaret Speer

(a) RESIDENCE NO. 2230 E Hoffman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Speer

6 DATE OF BIRTH (month, day, and year): July 4-1877

7 AGE: Years 44 Months 9 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS
10 NAME OF FATHER: John Schnapp
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Christine Schnell
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Carl Schnapp 2230 E Hoffman

15 Filed APR 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12 1922 to April 20 1922.
that I last saw her alive on April 20 1922
and that death occurred, on the date stated above, at 12 50 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (Apoplexy) (duration) yrs. mos 8 ds.
CONTRIBUTORY (Secondary) Asthenia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) William Fronce M. D.
(Address) 1407 N Gay St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery
DATE OF BURIAL: Apr 27 1922

20 UNDERTAKER: J Herwig & Co
ADDRESS: 2008 Eutaw

mation should be carefully supplied, so that it may be properly classified. Enter CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63685

D 63685

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 N. Gilmore ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Elizebeth Stansbury

(Residence in Baltimore: No. 1412 N. Gilmore St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 27, 1872 (Month) (Day) (Year)

7-AGE, 49 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... Housework (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Penn

PARENTS.

10-NAME OF FATHER, Henry T. Reaves

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER Julia Rice

13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theadora M. Stansbury

(Address) 1412 N. Gilmore St.

15- Filed APR 24 1922, 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 22 1922, to Apr 23 1922, that I saw her alive on Apr 23 1922, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Uterus & Bladder)

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Homer C. Todd M. D.

4/23, 1922 (Address) 735 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Apr. 25, 1922

20-UNDERTAKER George J. Smith

ADDRESS 1000 Fayette St

CAUSE OF DEATH in plain terms, so that any one may understand it. All items are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63686

CERTIFICATE OF DEATH.

90 D 63686

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Age. (Women's Home 19 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Hardisty

(Residence in Baltimore: No. 1400 W Lexington St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, Oct (Month) 27 (Day), 1848 (Year)

7-AGE, 73 yrs. c mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), D. C. Co Md

PARENTS.

10-NAME OF FATHER, Richard Jones

11-BIRTHPLACE OF FATHER (State or Country), D C Co Md

12-MAIDEN NAME OF MOTHER Elizabeth Conners

13-BIRTHPLACE OF MOTHER (State or Country), D.C. Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella J Jones

(Address) Watrous

15-

Filed. APR 24 1922 GLG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apl 21, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 191..., to Apl 21 191..., that I saw h... alive on Apl 21 191..., and that death occurred, on the date stated above, at 2 45 p m.

The CAUSE OF DEATH* was as follows:

Chronic Diseases of Heart

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) 1 yrs. 7 mos. ds.

(Signed) J H Marwood M. D.

Apl 23, 1922 (Address) 1500 Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Apl. 25 1922

20-UNDERTAKER George J Smith

ADDRESS 1000 Fayette St

CAUSE OF DEATH to be plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 63687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 63687

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 Garrison Ave. 15 WARD)

2-FULL NAME Gladys K. Rhode

(a) RESIDENCE. No. 2901 Garrison Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5 If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 24. 1900

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	21	4	21	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school (1914)

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 000

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Martin Rhode Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie E. Klees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md.

14 Informant Martin Rhode Jr.
(Address) 2901 Garrison ave.

15 Filed APR 24 1922 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1922, to 4. 21, 1922, that I last saw her alive on 4. 20, 1922, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) 7 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Syncope from Extraction (duration) X yrs. X mos. 1 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? City Health Dept.

4/22, 1922 (Signed) P Bledsoe, M. D.

(Address) 1124 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	April 24 1922
20 UNDERTAKER Wm J. Tickner & Son	ADDRESS Monument Square

Information should be carefully given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Ernst

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63688

CERTIFICATE OF DEATH.

159 D 63688

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. 912 Russell ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Wm~~ Margaret Mary Ernst

(a) RESIDENCE. No. 912 Russell St. WARD.

(Usual place of above)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 23, 22

7 AGE: Years — Months 9 Days — If LESS than 1 day, hrs. or min.: 9 months in utero

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Ernst

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Margaret Davidson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Wm Ernst

(Address): 912 Russell St.

15 Filed . 19 APR 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-23- 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-23- , 19 22 to 4-27- , 19 22

that I last saw h alive on 4-23- , 19 22

and that death occurred, on the date stated above, at 9 4 m.

The CAUSE OF DEATH* was as follows:

Failure of Pregnancy

or ante Partum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dorsey M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: April 24 1922

20 UNDERTAKER: F. B. Kupfrian

ADDRESS: 2336 Fred'k ave

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificate.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63689

CERTIFICATE OF DEATH.

118 D 63689

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Breit

(a) RESIDENCE NO. 209 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 16 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Alfred J Breit

6 DATE OF BIRTH (month, day, and year) 9/15/1883

7 AGE — Years 38 — Months 7 — Days 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

031

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Alfred J Breit

(Address) 209 Mosher

15 Filed APR 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/22, 1922, to 4/22, 1922, that I last saw h~~e~~r alive on 4/22, 1922, and that death occurred, on the date stated above, at 10 15 ~~p~~ m.

The CAUSE OF DEATH* was as follows: Intestinal obstruction Adhesions. Laparotomy

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 209 Mosher St.

Did an operation precede death? yes Date of 4/22/22

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. D. Douglass, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 4/25 1922

20 UNDERTAKER William Cook — ADDRESS 502 E North

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63690

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5-5-20 York Road ST., 27 WARD)

2-FULL NAME John D. Jefferson

(a) RESIDENCE NO. 5-5-20 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora A. Jefferson

6 DATE OF BIRTH (month, day, and year) Feb 29 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Clayborne Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alicia Mayhew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Dora A. Jefferson (Address) 5-5-20 York Road

15 Filed APR 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1922

17 I HEREBY CERTIFY, That I attended deceased from February 2, 1922, to April 22, 1922, that I last saw h[illegible] alive on April 21, 1922, and that death occurred, on the date stated above, at 12.5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Autointoxication

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumin in urine

(Signed) S. W. Bishop, M. D.

Apr 22 1922 (Address) 501 Shendandoah

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	April 25 1922
20 UNDERTAKER Wm Cook	ADDRESS N & G Ave.

mation should be carefully written, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—I-10-21—M&T—1500 Bks.

D 63691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63691

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 406 East 27th ST., 12 WARD)

2-FULL NAME Annie Hartzell

(a) RESIDENCE NO. 406 E. 27th ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write word) Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Martin L. Hartzell

6 DATE OF BIRTH (month, day, and year) Dec 22-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER John Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Martha Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Jacob Hartzell (Address) 406 E. 27th

15 APR 24 1922 Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1922, to April 21, 1922, that I last saw her alive on April 21, 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Syncope

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Wm J. Dunbury, M. D.

, 19 (Address) 415 Cedarcroft Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn.

DATE OF BURIAL 4/24 192

20 UNDERTAKER William Cook

ADDRESS 502 North

mation should be carefully supplied. Note—Be sure that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63692

CERTIFICATE OF DEATH.

113 D 63692

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 E. Baltimore ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Byrne

(Residence in Baltimore: No. 3031 E Baltimore St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Apr. (Month) 8 (Day), 1921 (Year)

7-AGE, ...yrs. 11 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Robert Byrne

11-BIRTHPLACE OF FATHER (State or Country), Balt. Md.

12-MAIDEN NAME OF MOTHER Ethel Coyne

13-BIRTHPLACE OF MOTHER (State or Country), Jersey City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Byrne

(Address) 3031 E Balt. St.

15-

FILED APR 24 1922 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 10 1922, to Apr 22 1922, that I saw her alive on April 22 1922, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) E D Britton M. D.

Apr 23, 1922 (Address) 1711 E Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, April 24, 1922

20-UNDERTAKER William Cook ADDRESS 502 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63693

HEALTH DEPARTMENT—CITY OF BALTIMORE

081 63693

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hosp ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Peiser

(a) RESIDENCE. NO. 613 W Franklin ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of Max Peiser

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Herman Berkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lizette Stark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Max Peiser (Address) 613 Franklin St

15 Filed . 19 APR 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to April 22, 1922, that I last saw h e alive on April 22, 1922, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy + uremia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) T. Frederick Lentz, M. D.

4/22, 1922 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL 4/24 1922

20 UNDERTAKER J Ahrens Cem — ADDRESS 1611 Kutsan

mation should be entered in these columns, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 63694

CERTIFICATE OF DEATH.

X 101 D 63694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 McDonough ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Parks

(a) RESIDENCE NO. Glenridge N. J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Ellen C. Tubman Parks

6 DATE OF BIRTH (month, day, and year): July 11, 1861

7 AGE: Years 60, Months 9, Days 12. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Maryland

PARENTS

10 NAME OF FATHER: Henry Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Emilia Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. E. Van Sant

(Address): Glenridge N.J.

15 APR 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 17, 1922, to Apr 23, 1922, that I last saw h e alive on Apr 23, 1922, and that death occurred, on the date stated above, at 8.40 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Ruhrmund, M. D.

4/23 1922 (Address) 3524 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Apr 24 1922

20 UNDERTAKER: Robt Kemmer Sons

ADDRESS: 1 & 2 Bway

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 63695

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-005 D 63695

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Edmondson ST., 19 WARD)

2-FULL NAME Milton Johnson

(a) RESIDENCE NO. 1607 Edmondson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Francis Johnson

6 DATE OF BIRTH (month, day, and year) July 20, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	9	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cutter and Designer of Clothing
(b) General nature of industry, business, or establishment in which employed (or employer) Men clothing
(c) Name of employer H. Lange.

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Samuel Johnson

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Oliver

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country)

14 Informant Francis Johnson (Address) 1607 Edmondson Ave

15 Filed APR 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 22, 1922, that I last saw h alive on April 21, 1922, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

T B of right Kidney with
general Involvement of Syst

(duration) 30 yrs. mos ds.

CONTRIBUTORY (Secondary) a general disease (duration) yrs. mos. ds. contracted

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 1890

Was there an autopsy?

What test confirmed diagnosis? History & Clinical

(Signed) Bernard Lemmel, M. D.

4/23, 1922 (Address) 1709 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEM. DATE OF BURIAL 4/25 1922

20 UNDERTAKER ROBERT BROOKS SON ADDRESS CALHOUN HOLLINS STS

N. B.—Blanks should be carefully supplied. Any information should be properly classified. Exact statements CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

(Sturterant) ✓

D 63696 HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 63696

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 Oakland Ave ST.: 27 WARD)

2-FULL NAME Richard Charles Sturterant Jr

(a) RESIDENCE. NO. 516 Oakland Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Chas. Sturterant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa (Sioux city)

12 MAIDEN NAME OF MOTHER Anna V. Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Richard C. Sturterant Jr

(Address) 516 Oakland Ave

15 Filed APR 21 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1922, to Sept 22, 1922, that I last saw h[illegible] alive on Sept 21, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings.

(Signed) H. W. Preston, M. D.

, 19 (Address) 4275 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery. DATE OF BURIAL Sept 25 1922

20 UNDERTAKER E. Lamb Gore ADDRESS 1733 W. Lafayette Ave

mation should be carefully written in ink, in plain terms, so that it may be properly classified. Particularly CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of any prior infection

Spec.—6-3-19—H. P. Co.—1000 Bks.

Groni

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 63697

CERTIFICATE OF DEATH.

74 D 63697

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S Dallas ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blazy Groni

(a) RESIDENCE. No. 417 S Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Jawdakia Groni

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Curtis Bay Car Shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Peter Groni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Sylvester Groni (Address) 509 S. Regester

15 FILED APR 24 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APRIL 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to April 23, 1922, that I last saw h[illegible] alive on April 23, 1922, and that death occurred, on the date stated above, at 130 A.M.

The CAUSE OF DEATH* was as follows:

Central Apoplexy

(duration) yrs. ca mos. 20 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank B. Jawyrski M. D.

4/23, 1922 (Address) 245 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	APRIL 25 1922

20 UNDERTAKER John M Weber ADDRESS 1803 Bank

mation should be carefully written in ink, in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63698 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63698

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Nikolaiczyk

(a) RESIDENCE. NO. 1628 Shakespeare ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Nikolaiczyk

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address) Municipal Hospital.

15 Filed APR 24 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 21 19 22, to April 22, 19 22, that I last saw him alive on April 22, 19 22, and that death occurred, on the date stated above, at 10:05 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. few ds.

CONTRIBUTORY (Secondary) Pneumonia Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/24/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	APRIL 24 1922
20 UNDERTAKER John M. Weber	ADDRESS 1803 Bank St

Before signing, be sure that you have entered the CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Winder

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 63699

CERTIFICATE OF DEATH.

90 D 63699

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 405 Mc Allister ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Frances Wonder

(a) RESIDENCE. No. 405 Mc Allister ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow Gunnison

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Work at Iron Mill

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg and Ironing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER Robt H Wonder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Ellen Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 ✓ Informant William J Winder (Address) 405 Mc Collister St

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar Burial Permit Clerk. APR 24 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to April 21, 1922, that I last saw h[illegible] alive on April 21, 1922, and that death occurred, on the date stated above, at 1 35 A. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald L. Tonry, M. D.

, 19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 30, 1922
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

mation should be given in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63700

D 63700

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1215-Cathedral-St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME BELLE RENWICK STEWART.

(a) RESIDENCE. No. 1215-Cathedral-St. ST., 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? 60 yrs. 2 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Jan-28-1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer). None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John D. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary E. Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mr. Harry L. Stewart (brother)
(Address) #1215-Cathedral-St., City.

15 Filed APR 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1921, to Apr 22, 1922, that I last saw her alive on Apr 22, 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Path. & Gen. Clin.

(Signed) Ernest P. Gaither, M. D.

, 19 (Address) #17 N. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April-25-1922
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63701

CERTIFICATE OF DEATH.

90 D 63701

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #237-E-Lafayette-Av. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Howard Stirling

(a) RESIDENCE. No. #237-E-Lafayette-Av. ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 61 yrs. 11 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Sellers Stirling

6 DATE OF BIRTH (month, day, and year) April-25-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broker.

(b) General nature of industry, business, or establishment in which employed (or employer) Investments.

(c) Name of employer Stirling Investment Co.

9 BIRTHPLACE (city or town) New York City
(State or country) New York

PARENTS

10 NAME OF FATHER Douglas Stirling

11 BIRTHPLACE OF FATHER (city or town) New York City
(State or country) New York.

12 MAIDEN NAME OF MOTHER CorneliaH. Elder

13 BIRTHPLACE OF MOTHER (city or town) GreenSprgVally
(State or country) Balto. co/Maryland.

14 Informant David S. Stirling, (son)
(Address) 237-E-LaFayette-Av., City.

15 APR 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April. 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16th, 1922, to April 23, 1922, that I last saw him alive on April 21st, 1922, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

several
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. W. Keown, M. D.

Apl 23 1922 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Thomas' Garrison Forest.	Apr-25-22
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63702

CERTIFICATE OF DEATH.

11H D 63702

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 N. Calhoun ST., 16 WARD)

2-FULL NAME James O. Randall

(a) RESIDENCE NO. 917 N. Calhoun ST., WARD

(Usual place of abode) Live

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1919.

7 AGE — Years: 2 — Months: 6 — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: baby ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Solomon Randall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Carrie Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Solomon Randall

(Address) 917 Calhoun

Filed APR 24 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1922 to April 22, 1922

that I last saw him alive on April 20, 1922,

and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Cearly, M. D.

April 24 1922 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 4/24/22

20 UNDERTAKER: Samuel W. Chase-son — ADDRESS: 1400 Hoshen St

mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT [illegible] TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Child not properly nourished. Toxaemia and probably some gastro enteritis.
Mother had nursed child until over 2 yrs of age.

D 63703 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 63703

CERTIFICATE OF DEATH.

90

1 PLACE OF DEATH REGISTERED No. C

CITY OF BALTIMORE (No. Died in Penna R.R. Car near Bally St. ... WARD)

Pronounced dead at Mercy Hosp

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frank Stanley

(Residence in Baltimore: No. — Unknown St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Unknown

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. about 30 yrs ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J Riley

(Address) 639 N Broadway

15- APR 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

Filed ..... 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal Chronic Nephritis

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Prob. Tuberculosis

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

April 23 1922 (Address) 1639 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincents Cemetery — DATE OF BURIAL, 4/27, 1922

20-UNDERTAKER E J Fanning & Son — ADDRESS 1938 E Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63704

REGISTERED NO. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Dukeland ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Koller.

(a) RESIDENCE. No. 1804 Dukeland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo. L. Koller.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mamie L. Milligan

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant George L. Koller
(Address) 1804 Dukeland St

15 Filed APR 24 1922

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1922, to 4-24, 1922

that I last saw h alive on 4-23, 1922

and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 4/24/22 2757 W. Monument.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	4/24 1922
20 UNDERTAKER Williams Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH must be stated plainly, and as many lines used as may be necessary. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63705 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63705

CERTIFICATE OF DEATH.

16 161 REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Appleton st ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Elizabeth Walker

(Residence in Baltimore No. 1108 Appleton st St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Sin

6-DATE OF BIRTH, March (Month) 17 (Day), 1921 (Year)

7-AGE, ... yrs. 1 mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER. Harry C. Walker

11-BIRTHPLACE OF FATHER (State or Country). Pa

12-MAIDEN NAME OF MOTHER Mari Lastner

13-BIRTHPLACE OF MOTHER (State or Country). Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Harry C. Walker

(Address) 1108 Appleton st

15- APR 24 1922 Filed ....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 23 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 31 1922, to apr 23 1922, that I saw h[illegible] alive on apr 23 1922, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth

Marasmus

(Duration) ..... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) H E Krumpe M. D.

Apr 24, 1922. (Address) 1002 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cy DATE OF BURIAL, April 24, 1922

20-UNDERTAKER Jos Joerdens + Son ADDRESS 217 S. Paca st.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63706

CERTIFICATE OF DEATH.

1-D 63706

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Dietrick Linnenbaum

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Dietrick Linnenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed APR 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to April 23, 1922, that I last saw him alive on April 22, 1922, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) ..... yrs. 4 mos. Wks. ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

4/24/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 4/25 1922

20 UNDERTAKER [signature]

ADDRESS 522 E Nath

N. B. All information should be carefully supplied. Note may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63707

CERTIFICATE OF DEATH.

49 D 63707

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 E Biddle ST., 10 WARD)

2-FULL NAME James P Finigan

(a) RESIDENCE No. 619 E Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Finigan

6 DATE OF BIRTH (month, day, and year): Aug 5 1870

7 AGE — Years: 51 — Months: 8 — Days: ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 030

(c) Name of employer: Fleischmann Yeast Co

9 BIRTHPLACE (city or town) (State or country): Laurel Md

PARENTS

10 NAME OF FATHER: Bernard Finigan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Laurel Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Laurel Md

14 Informant (Address): Mary E Finigan 619 E Biddle

15 Filed APR 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1919 to April 23 1922

that I last saw him alive on April 23, 1922

and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of ... (over)

Was there an autopsy? .....

What test confirmed diagnosis? None

(Signed) Geo. C Bowden M. D.

4/23 1922 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Harford Co Md — DATE OF BURIAL: April 25 1922

20 UNDERTAKER: William Balsar — ADDRESS: E Balto

N.B. ... mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 63708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63708

CERTIFICATE OF DEATH.

REGISTERED NO. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hobbs

(a) RESIDENCE. NO. Pikesville Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 21, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or — min.
			7 hrs	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John E. Hobbs

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Beatrice Orefelden

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mercy Hospital Records
(Address)

15 Filed APR 24 1922 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1922 to Apr 22, 1922

that I last saw him alive on Apr. 22, 1922

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac failure 7 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) John J. Crum, M. D.

(Address) St Mary's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Retained at Mercy Hosp	
20 UNDERTAKER	ADDRESS

mation should be carefully supplied, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63709

CERTIFICATE OF DEATH.

161-001

D 63709

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 842 W. Pratt ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 842 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (0 D)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Earl Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Bessie McDiffenbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Earl Smith (Address) 842 W. Pratt st

15 FILED APR 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/1922

17 I HEREBY CERTIFY, That I attended deceased from 4/23/22 19 , to 4/24/22 19 ,

that I last saw h— alive on 4/23/22 , 19 ,

and that death occurred, on the date stated above, at 4:35 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (6 hrs.)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Steiny, M. D.

(Address) 910 Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 24 1922
20 UNDERTAKER James Dignan & Son	ADDRESS 1000 S. Paca St

N. B. Information should be carefully supplied. Note that it may be properly classified. DATE of CAUSE OF DEATH in plain terms, so

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63710

CERTIFICATE OF DEATH.

3 | D 63710

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 S. Potomac ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Donnelly.

(a) RESIDENCE. NO. 1122 S. Potomac ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Clo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Jos. Donnelly

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Murphy

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Margaret A. Donnelly
(Address) 1122 S. Potomac St

15 APR 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to April 22, 1922, that I last saw him alive on april 22, 1922, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M J McAvoy, M. D.

4/22, 1922 (Address) 839 O. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 25 1922
20 UNDERTAKER Lilly & Jeiler	ADDRESS 400 N. Howard St

N. B.—WHITE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See affadivit over)

D 63711

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63711

H 1

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin A. Luck

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred UK yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, (Married) or Divorced (Widowed) (write word) (Married)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE: Years 78 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard Co. Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Hospital Records Municipal Hospital

15 Filed Robert P. Harrison, Registrar

APR 24 1922 [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922 to April 20, 1922, that I last saw h[illegible] alive on April 20, 1922 and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of left leg- (apparently Streptococcic in character) (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical study-

(Signed) L. A. Brumbock, M. D.

4/24/1922 Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lowell Cemetery

DATE OF BURIAL: April 19

20 UNDERTAKER: Commissioner Health, Per. Wm. E. Woodall

ADDRESS

(OVER)

Information should be carefully verified, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Baltimore, Md., April 27, 1922.

I do hereby make oath that Benjamin F. Leek whose death is recorded on Baltimore City Health Department Certificate of Death D-63711 as Widowed, is not correct; same should be recorded as Married.

Mrs Maggie Lee
Wife.

Subscribed and sworn to before me this 27th day of April, 192

Fred Gaither
Notary Public.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63712

CERTIFICATE OF DEATH.

D 63712

REGISTERED No. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Wellington ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Enoch Rankin Cullison.

(Residence in Baltimore: No. (Life) 809 Wellington St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White,	Divorced

6-DATE OF BIRTH, 3 (Month) 4 (Day), 1878 (Year)

7-AGE,	If LESS than 1 day,
44 yrs. 1 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ret'd

9-BIRTHPLACE, (State or Country), Baltimor City.

PARENTS.

10-NAME OF FATHER, Enoch Cullison.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Emma C. Fillmore

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John B. Mitchell

(Address) 809 Wellington St.

15-

Filed....., 191.. Robert B. Harriman, Registrar.

R 24 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 23rd (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 5th 1922, to April 23 1922, that I saw h.. alive on April 23 1922, and that death occurred, on the date stated above, at 4 15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage probably Tubercular (Duration) yrs. mos. 15 ds.

(Signed) H. A. Fries M. D.

April 24th, 1922 (Address) 15 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden

DATE OF BURIAL, Apr. 26, 1922

20-UNDERTAKER Walter R McNamee

ADDRESS 809 Wellington St

B. Every item must be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63713

CERTIFICATE OF DEATH.

78 D 63713

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 20 ST., WARD)

2-FULL NAME Eugene Lonstm Hartman

(a) RESIDENCE NO. 1902 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
21.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John L. Hartman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Bayview Hosp.
(Address) Balto, Md.

15 Filed Robert [illegible] 19
Burial Permit Clerk. Registrar

APR 24 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1921, to April 22, 1922, that I last saw him alive on April 21, 1922, and that death occurred, on the date stated above, at 6:50 a.m.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Feldsmith M. D.

4/24 1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL April 25 1922

20 UNDERTAKER David Earlam

ADDRESS [illegible] Pennsylvania

Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. SECTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63714

CERTIFICATE OF DEATH.

D 63714

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 213 N. Fulton Avenue (St.) (19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward McColgan Kenney

(a) RESIDENCE. NO. 213 N. Fulton Avenue St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma I. Stembler

6 DATE OF BIRTH (month, day, and year) May 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	11	16	

086

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moving picture Theatre

(b) General nature of Industry, business, or establishment in which employed (or employer) Manager

(c) Name of employer Clover Theatre

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jeremiah Kenney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Mary Guilema Watson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U. S. A.

14 Informant Mrs. Emma I. Kenney
(Address) 213 N. Fulton Avenue

15 Filed Apr 24 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1922

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1922, to April 22, 1922, that I last saw h[illegible] alive on April 22, 1922, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia
Arteriosclerosis
Cerebral Hemorrhage
(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Oedema of lungs
(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw'd Coolahan, M. D.
4/24, 1922 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	4/25, 1922.
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63715

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 W. Fayette ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Geraghty

(a) RESIDENCE NO. 2101 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bartley Geraghty

6 DATE OF BIRTH (month, day, and year) Jan. 29-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jeremiah Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Coulon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mr. Geraghty

(Address) 2101 W. Fayette St.

15 Filed , 19 Registrar

Burial No. 811 Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23rd, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to April 23, 1922, that I last saw her alive on April 21, 1922, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia, high Art. Tension

(Signed) Charles O Brosman, M. D.

, 19 (Address) 5 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL 4/26 1922

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 1184 Mt. Royal ave.

2 24 1922

Be sure that information should be carefully supplied. ACCURATE and COMPLETE. Each statement of fact should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63716

D 63716

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 311 Caton Ave. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Oliver Butler

(a) RESIDENCE NO. 311 Caton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Butler

6 DATE OF BIRTH (month, day, and year) Sept. 27th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Schaeffer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Stephen Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Margaret A. Stewart

(Address) 311 Caton Ave.

15 Robert P. Harrison, Registrar

Apr 24 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22nd 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16 1922 to April 22 1922

that I last saw him alive on April 22 1922

and that death occurred, on the date stated above, at 10.35 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

Apr 22nd 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL, Apr. 25 1922

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W Pratt St

B.—WRITE plainly and carefully supplied. AGE should be properly classified. Exact statement of mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 63717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 D 63717

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Frances Van Horn

(Residence in Baltimore: No. 879 Hollins Street St.; yrs., 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.)
Female	White	Married

6-DATE OF BIRTH, July 19th. (Month) (Day), 1900 (Year)

7-AGE, 21 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Mt. Alto, Pa.

PARENTS.

10-NAME OF FATHER, Owen Wise

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Rodenhiser

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Alice Dove

(Address) 879 Hollins St.

15- Robert P. Harrison,

Date....., 191..... Burial Permit Clerk. Registrar.

R 24 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April, 23rd. (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fortuan reef medicine

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) [illegible] M. D.

(Coroner)

4-24, 1922 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Williamsport, Md. DATE OF BURIAL, April 25, 1922

20-UNDERTAKER Joseph D Cook ADDRESS 1003 N. Bath St

N.B.—Every item of information should be given if possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 63718

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-0020 63718

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Hillman ST., 10 WARD)

2-FULL NAME Susanna E. Lee

(a) RESIDENCE NO. 1020 Hillman ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lee

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~74~~	73	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Vienna Ohio

PARENTS

10 NAME OF FATHER Henry Shaunger

11 BIRTHPLACE OF FATHER (city or town) Pittsburg (State or country) Penn'

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Greenville (State or country) Penn'

14 Informant Geo W Lee

(Address) 1020 Hillman St

15 Filed ..... 19.... Registrar

APR 24 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922 to April 23, 1922 that I last saw h— alive on April 23, 1922 and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James McAuliffe M. D.

4 23. 1922 (Address) 707 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL April 26 1922

ADDRESS

20 UNDERTAKER Wm Cook 1026 E Northern

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be given in years, months and days. Exact statement of information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

D 63719 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63719

CERTIFICATE OF DEATH. 24 168 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1622 E. Fort Ave. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Marsek.

(Residence in Baltimore: No. 1622 E. Fort Ave. St.; yrs. 15 mos. ---------- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Widower

6-DATE OF BIRTH. Do not know. ..... 1..... (Month) (Day) (Year)

7-AGE. 46 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sheet metal
(b) General nature of industry, business, or establishment in which employed (or employer): worker. Oil

9-BIRTHPLACE, (State or Country). Hungary.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward B. Johns.

(Address) 1622 E. Fort Ave.

15- Filed ..... 192..... Robert P. Harrison, Registrar.

PR 24 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22nd. 1922. ..... (Month) (Day) (Year) 192.....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to n/a death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation.
Suicide by hanging.
(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....
(Duration) .....yrs. .....mos. .....ds.

(Signed) Otto K. Reinhardt M. D.
(Coroner.)

Oct. 24 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Yard — DATE OF BURIAL. 4/25 1922

20-UNDERTAKER. William Cook — ADDRESS 502 E North

B.—Every item of information should be properly classified. Exact statements should be made. In order that it may be properly classified, state CAUSE OF DEATH in plain terms, so that it may

Spec.—1-10-21—M&T—1500 Bks.

D 63720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63720

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3325 Piedmont Ave. WARD 15)

2-FULL NAME Lemuel T. Massey

(a) RESIDENCE NO. 3325 Piedmont Ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Massey

6 DATE OF BIRTH (month, day, and year) June 19 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 466

(b) General nature of industry, business, or establishment in which employed (or employer) Retail store

(c) Name of employer Kellum & Co

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Massey

11 BIRTHPLACE OF FATHER (city or town) Phila. (State or country) Penna

12 MAIDEN NAME OF MOTHER Annie L. Remsen

13 BIRTHPLACE OF MOTHER (city or town) Mannheim (State or country) Penna

14 Informant Mrs Margaret Massey (Address) 3325 Piedmont Ave

15 Filed Apr 24 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 3, 1922 to April 23rd, 1922, that I last saw him alive on April 23rd, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Lung (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Asthma myocarditis (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Niblett, M. D.

Apr 24/22, 19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	April 26 1922
20 UNDERTAKER	ADDRESS
A. Allen Fuller	3517 Springdale Ave

N. B.—WRITE plainly and should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 24 1922

(Waters)

D 6372 HEALTH DEPARTMENT—CITY OF BALTIMORE D 6372

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis H. Walters

(Residence in Baltimore: No. Lakewood Rd St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Nov. (Month) 18 (Day), 1865 (Year)

7-AGE, 56 yrs. 5 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Architect
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt md

PARENTS.

10-NAME OF FATHER, Edw G. Waters

11-BIRTHPLACE OF FATHER (State or Country), B. City

12-MAIDEN NAME OF MOTHER Mc A Hutch

13-BIRTHPLACE OF MOTHER (State or Country), Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Mary A. Waters

(Address) 171 Madison ave

15- Filed APR 25 1922, 19.. E. Wilhelm Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 23 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- Fractured Leg

a fracture (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) accidentally struck by auto (Duration) yrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

4-25, 1922 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, April 25, 19.22

20-UNDERTAKER Henry D Jenkins

ADDRESS McCulloh & Orchard

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-10-21—M&T—1500 Bks.

D 63722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 63722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 Stockton ST., 16 WARD)

2-FULL NAME Charles Maker

(a) RESIDENCE NO. 1038 Stockton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Maker

6 DATE OF BIRTH (month, day, and year) Mar 10, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Richard Maker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md.

12 MAIDEN NAME OF MOTHER Sarah Isaacs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Charles Hall

(Address) 1038 Stockton St

15 FILED APR 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1922, to Apr 22, 1922,

that I last saw him alive on Apr 21, 1922,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Odd

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary findings

(Signed) E. William Frey, M. D.

4/22, 1922 (Address) 1938 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 25 19 22
20 UNDERTAKER	ADDRESS
Jno. H. Chase Bro	Hartford

NOTICE—Information should be carefully supplied. AGE should be accurately stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition. Possibly chronic condition.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63723

D 63723

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Brookfield Ave WARD 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon S. Block

(a) RESIDENCE NO. 2115 Brookfield Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa Block

6 DATE OF BIRTH (month, day, and year): July 22, 1841

7 AGE — Years: 80 — Months: 9 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Mnfg.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Simon J. Block

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Rider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: S. Block

(Address) 2115 Brookfield Ave

15 Filed APR 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1920, to April 23, 1922, that I last saw h[er] alive on April 23, 1922, and that death occurred, on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Diabetes - arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) myocarditis - diabetes

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D.

4/23, 1922 (Address) 2040 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Heb. Cem. — DATE OF BURIAL: 4/25 1922

20 UNDERTAKER: David Sondheim — ADDRESS: 115 W. Mt. Royal Ave.

mation should be given in plain terms, so that it may be proper. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63724

D 63724

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 514 N. Luzerne Ave. ST., 7 WARD)

2-FULL NAME Laura W. Snyder

(a) RESIDENCE NO. 514 N. Luzerne Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—Write plainly. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Snyder

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work AT HOME

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William F. Moebius (Address) 514 N. Luzerne Ave.

15 APR 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1921 to April 24 1922 that I last saw h[illegible] alive on April 23 1922 and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Albuminuria

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. F. Eby, M. D.

H't 1922 (Address) 677 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/26 1922

20 UNDERTAKER Chas. F. Evans & Son

ADDRESS 1811 W. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

55367

63725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 63725

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME James Ford

(a) RESIDENCE NO. 415 Hoover St - City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	—	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Richard Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hattie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 APR 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 24, 1922, that I last saw him alive on April 24, 1922, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) ... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes - Final report not in.

What test confirmed diagnosis? Blood analysis.

(Signed) A. B. Mead, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL April 25, 1922

20 UNDERTAKER Wm R A Elliott — ADDRESS 1225 Ashland Av

N. B. Information should be carefully supplied. AGE should be given in years, months and days. Exact statement of occupation is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63726

CERTIFICATE OF DEATH.

D 63726

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 Longwood ST., 15 WARD)

2-FULL NAME James Walter Macneal

(a) RESIDENCE NO. 1800 Longwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 080

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James W Macneal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Helen Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant James W Macneal
(Address) 1800 Longwood St.

15 Filed APR 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1922, to Apr 24, 1922, that I last saw him alive on Apr 23, 1922, and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchos pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Measles (duration) 1 yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) J E D W Dalton, M. D.

. 19 (Address) 353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Baltimore Md.

DATE OF BURIAL April 25 1922

ADDRESS 2238 N Howard

20 UNDERTAKER W. M. Rountree

N. B.—Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63727

D 63727

CERTIFICATE OF DEATH.

REGISTERED NO. C 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2801 Windsor Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert G. Cooper

(Residence in Baltimore: No. 2801 Windsor Ave St.; 3 yrs., 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 28 (Day), 1848 (Year)

7-AGE, 74 yrs. — mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Bozman Talbot Co Md

PARENTS.

10-NAME OF FATHER, Richard W. Cooper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ann Grace

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ann Virginia Cooper

(Address) 2801 Windsor ave

15- Filed APR 25 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 24 (Day), 1922 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1922, to Apr. 24, 1922, that I saw him alive on Apr. 22, 1922, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

60. (Duration) yrs. mos. ds.

(Signed) C. T. Dickey M. D.

Apr. 24, 1922 (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Michaels Md

DATE OF BURIAL, April 25, 1922

20-UNDERTAKER Chas. G. Black

ADDRESS 742 Dorothy Ave

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 63728

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 N Pratt ST.: 19 WARD)

2-FULL NAME Henry W Kentz

(a) RESIDENCE. NO. 1619 N Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Katherine Kentz

6 DATE OF BIRTH (month, day, and year) Nov 24 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo. Kentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Katherine Kentz

(Address) 1619 N Pratt St

15 Filed APR 25 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1921, to April 23, 1922

that I last saw h alive on April 23, 1922

and that death occurred, on the date stated above, at 4-20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

April 24, 1922 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Apr 26 1922

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1831 W Lombard

N. B. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63729

CERTIFICATE OF DEATH.

74-001

D 63729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST., No WARD)

2-FULL NAME Chas. E. Sheppard

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Shucker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed APR 25 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1922, to April 24, 1922, that I last saw him alive on April 23, 1922, and that death occurred, on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

4/24/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery. DATE OF BURIAL 4/25 1922

UNDERTAKER Mrs. Geo. H. Enyon ADDRESS 406 W. Conway St

N. B.—Physician should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63730

CERTIFICATE OF DEATH

164 D 63730

REGISTERED NO.

1-PLACE OF DEATH Cantero Sanatorium Govans Md

CITY OF BALTIMORE: (No. 1023 Greenmount ST. Ed WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Morrow

(a) RESIDENCE. No. 1823 Greenmount ST. Ge WARD. 10

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. G. Morrow

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65 Y		—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Lavery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not None

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Andrew D. Morrow

(Address) 622 Laurens St

15 Filed ....., 19.....

Registrar

APR 25 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1922, to April 23, 1922, that I last saw h.. alive on April 23, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chron Bronchitis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Keen M. D.

4-24 1922 (Address) 5700 York Rd. Balto Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents — DATE OF BURIAL April 26 1922

20 UNDERTAKER E A Weedfield Jr — ADDRESS 501 E 22

8

mation should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

General breakdown
due to old age.
No chronic heart
disease no chronic
nephritis. Senility.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63731

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Shaudrey K.

(a) RESIDENCE. NO. 113 S. Spring ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Shaudrey K.

6 DATE OF BIRTH (month, day, and year) January-4-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant E. D. Shorey
(Address) Warden

15 Filed APR 25 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-22 1922

17 I HEREBY CERTIFY, That I attended deceased from March-30, 1922, to April-22, 1922, that I last saw him alive on April-22, 1922, and that death occurred, on the date stated above, at 6.10 p. m.

The CAUSE OF DEATH* was as follows:

Toxemia, Exhaustion, Cardiac failure
Septicemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Prostatic Abscess
(Tuberculosis) (duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 10-1922

Was there an autopsy? No

What test confirmed diagnosis? Incision & finding pus.

(Signed) William H. Schwartz, M. D.

4/23, 1922 (Address) Md. Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Penna DATE OF BURIAL April 25 1922

20 UNDERTAKER Wm. Wyper & Son ADDRESS 3 Bl...

A. B. C. ... should be carefully supplied. AGE should be stated ... Exact statement of OCCUPATION should be carefully supplied. AGE should be stated ... Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63732 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63732

CERTIFICATE OF DEATH. X 179

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) St. Agnes Hospital ST., 25 WARD)

2-FULL NAME Michael Nylsh.

(a) RESIDENCE NO. ..... Lutherville, Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND OF (or) WIFE OF: Wife. Humfrey Nylsh

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 69 yrs. Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Officer No 1
(b) General nature of Industry, business, or establishment in which employed (or employer): .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant (Address): Wife. Humfrey Nylsh Lutherville Md

15 APR 25 1922 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-24 1922

17 I HEREBY CERTIFY, That I attended deceased from 1-25, 1922, to 4-24, 1922, that I last saw him alive on 4-24 1922 and that death occurred, on the date stated above, at 4:40 A m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Insufficiency
Myocarditis - Chronic ?

..... (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Failure Pulmonary Oedema (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Josephs. Texas Md.

DATE OF BURIAL: April 27th 1922

20 UNDERTAKER: Leo G. Cook

ADDRESS: North Harford Ave

N. B.—WRITE PLAINLY, with pencil. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63733

D 63733

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jackson

(a) RESIDENCE. NO. 803 Lafayette ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Jackson

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer U/O

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Martha Wisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) U. of M.

15 APR 25 1922 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to April 20, 1922, that I last saw him alive on April 20, 1922, and that death occurred, on the date stated above, at 2-27 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglicca M. D.

4-20-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL: APR 25 1922

20 UNDERTAKER Commissioner Health. ADDRESS

For Wm. E. WOODALL

Sec.—WRITE [illegible] mation should be carefully supplied. AGE should be stated [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63734

D 63734

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eginio Romero

(a) RESIDENCE. No. 1623 Thames st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER John Romero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Juana Fear

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Hospital Records UNIVERSITY OF MARYLAND.

(Address) Robert P. Hartman,

15 APR 25 1922 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 23 19 22, to April 23. 1922.

that I last saw him alive on April 23. 1922.

and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dadaglialls M. D

4-24 19 22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

19

20 UNDERTAKER Commissioner Health ADDRESS APR 25 1922

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63735

D 63735

CERTIFICATE OF DEATH.

REGISTERED NO. 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Warner St. Mt. Winans (near Annapolis Rd) ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mahaley Burley

(a) RESIDENCE. NO. Warner St. Mt Winans ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Horace Burley

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE — Years: 64 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Ho

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ga. Co. Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Martha Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co. Md.

14 Informant (Address): Samuel Downey Mt Winans Md

15 Filed APR 25 1922, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/23/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/14/ 1922 to 4/23/ 1922, that I last saw her alive on 4/22/ 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J B Hawkins, M. D.

4/25/ 1922 (Address) 1216 Omig Hilg Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Bal

DATE OF BURIAL: April 27 1922

20 UNDERTAKER: David Earbee

ADDRESS 916 Ba

mation should be carefully supplied. Age should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63736

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 E Baltimore ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Marguerite Haas

(a) RESIDENCE NO. 1500 E Baltimore ST., 2 WARD Eighth Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Haas

6 DATE OF BIRTH (month, day, and year): June 20 1876

7 AGE: 45 Years 10 Months 4 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: John Jacob Beil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Sauers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Geo. J. Beil

15 Filed APR 25 1922, 19 Registrar

Robert P. Harrison.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1921, to April 24, 1922, that I last saw her alive on April 24, 1922, and that death occurred, on the date stated above, at 2 15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Urine

(Signed) Alfred A Braddock M. D.

4-25-1922 (Address) 66 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: April 26, 22

20 UNDERTAKER: Louis Heeman — ADDRESS: 326 Broadway

Spec.—1-10-21—M&T—1500 Bks. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. mation should be carefully supplied.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63737

CERTIFICATE OF DEATH.

REGISTERED NO. 99

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1448 Riverside Ave ST. 24th WARD)

2-FULL NAME Johanna Spaniol

(a) RESIDENCE. NO. 1448 Riverside Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Spaniol

6 DATE OF BIRTH (month, day, and year) Feb 13 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Thomas Burken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Wiltze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Clugett

(Address) 1448 Battery ave

15 Filed APR 25 1922 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/15/22, 19..., to 4/24/22, 19...,

that I last saw h alive on 4/24/22, 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Generalized Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) Edward Storrs, M. D.

4/24. 1922 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery (Brooklyn)	4/26/ 1922

20 UNDERTAKER ADDRESS

E J Fleming 1460 Battery ave

mation should be carefully supplied. Age should be stated. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

D 63738 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63738

CERTIFICATE OF DEATH.

24 161-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1440 Cooksie St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. McBeth.

(Residence in Baltimore: No. 1440 Cooksie St. St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	White.	Single.

6-DATE OF BIRTH. 7.15 a.m. April 23rd. 1922. (Month) (Day) (Year)

7-AGE. ---yrs.---mos.---ds.- If LESS than 1 day, 8 hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Charles A. McBeth.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Marie B. Meier.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles A. McBeth, (father)

(Address) 1440 Cooksie St.

15- [illegible] 192.....

Registrar.

R 25 1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3.30 p.m. April 23rd. 1922. (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth.

unknown.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Apl 24 192 2 (Address) 1019 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, April 26 1922

20-UNDERTAKER, M. Margaret Flynn ADDRESS, 477 Light St.

N. B.—Every item of information should be given as nearly as possible, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63739

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 D 63739

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Wm Hosp ST., 21 WARD)

2-FULL NAME Dorothy Pratt

(a) RESIDENCE NO. 1341 Sargent ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	3	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Dft

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Roberry Pratt

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Wilson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mrs Lillie Kidwell
(Address) 1261 Carroll st

15 Filed ....., 19 .....
Registrar

R25 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/22

17 I HEREBY CERTIFY, That I attended deceased from 4/24/22, 19..., to 4/25/22, 19...,
that I last saw h.. alive on 4/25/22, 19...,
and that death occurred, on the date stated above, at 2 a m
The CAUSE OF DEATH* was as follows:

Pneumonia Acute
Empyema, Streptococcic Septicemia
Died 6 hours (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Cardiac failure
Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? ..... Date of .....
Was there an autopsy? —
What test confirmed diagnosis? Clinical Symptoms
(Signed) J. Wm Kerr M. D.
, 19 (Address) Mt Wm Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Mount Olivet Cem Apr 27 1922

20 UNDERTAKER — ADDRESS
Jos Joerdens Son 217 Park

B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63740 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63740

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 408 E. Biddle ST., 10 WARD)

2-FULL NAME Luther Jones Beatley

(a) RESIDENCE No. 408 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Beatley

6 DATE OF BIRTH (month, day, and year) Oct 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Waldron Beatley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Miriam Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Julia Beatley

(Address) 408 E. Biddle

15 Filed 19 Robert P. Harrison, Registrar

APR 25 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1922, to April 24, 1922, that I last saw h alive on April 24, 1922, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Joseph D. Heaning, M. D.

19 (Address) 1811 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 26 1922

20 UNDERTAKER H. J. Sidney's Sons — ADDRESS Norfolk

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63741

CERTIFICATE OF DEATH.

D 63741

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 25 WARD)

2-FULL NAME Joseph wisner

(a) RESIDENCE. NO. 1101 curtis st., CurtissBay WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie wisner

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank wisner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed APR 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from February 21, 1922, to April 24, 1922, that I last saw him alive on April 24, 1922, and that death occurred, on the date stated above, at 8.50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Lungs

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Francis L Dadaglieca M. D.

4-25 1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross DATE OF BURIAL 4/28 1922

20 UNDERTAKER Wm Gallagher ADDRESS 1618 East

N. B.—Name should be carefully supplied. AGE should be stated properly. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Gulghaire

D 63742 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63742

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Asylum Registered No. C 129

City of BALTIMORE: (No. ... St. ... Ward) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche Fulghaire

(Residence in Baltimore: No. 420 E Pine St. St.; yrs. 5 mos. ds.)

Married

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F. | 4-COLOR OR RACE C | 5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH. — — (Month) (Day) (Year)

7-AGE. 29 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work — (b) General nature of Industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE. (State or Country) Maryland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Bankard

(Address) Westminster Md

Filed APR 26 1922, 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr. 22 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) C. E. Blake M. D.

(Coroner)

1922 (Address) 1430 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Westminster | DATE OF BURIAL. 4/27 1922

20-UNDERTAKER. J H Bankard & Son | ADDRESS Westminster

N. B.—Every item of information should be carefully supplied. ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Coby

D 63743

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

38 D 63743

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

CITY OF BALTIMORE. (No.) ST., 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Coby.

(a) RESIDENCE NO. 815 Edisto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada Coby.

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years 39. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Baltimore Md

15 Filed APR 26 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921, to April 23, 1922, that I last saw him alive on April 23, 1922, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Tuttle Goldsmith M. D.

4/24/1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: April 26 1922

20 UNDERTAKER: John H. Toadvine ADDRESS 142 West Lexington St

N. B.—WRITE plainly. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63744 D 63744

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4 E Stockton St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Josephine Taylor

(Residence in Baltimore: No. 102 W Montgomery St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Femal	Colored	Widow

6-DATE OF BIRTH, (Month) (Day) (Year)

Unknown 1864

7-AGE, 58 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dietets nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Out Side

9-BIRTHPLACE, (State or Country). Balto Co.

PARENTS.

10-NAME OF FATHER. John Cromwell

11-BIRTHPLACE OF FATHER, (State or Country). Unk

12-MAIDEN NAME OF MOTHER. Unk

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgeana Bell

(Address) 102 W monty

15- APR 26 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Pierson M. D.
(Coroner.)

4-24 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Apr 26. 1922
20-UNDERTAKER,	ADDRESS
John H. Toudin	142 W. Hill St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that it may be properly classified.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63745

D 63745

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archie Thomas Estate

(Residence in Baltimore: No. 532 N. Bradford St., 40 St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M | 4-COLOR OR RACE. C | 5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH, ... 1..... (Month) (Day) (Year)

7-AGE 77 yrs. ..... mos. ..... ds. If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Waiter (b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Archie Thomas.

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Patterson

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Kelly

(Address) 532 N. Bradford St.

15-Filed APR 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Inquest, and found that said deceased came to ... death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Femur

Accidental Fall (one)

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia 3

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) M. D.

April 25 1922 (Address) 1211 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Druid Hill Cemetery | DATE OF BURIAL. April 26, 1922

20-UNDERTAKER. Edward Burton | ADDRESS 1631 Madison St

N. B.—Every item of information should be carefully supplied. Answers must be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63746 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63746

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH Norwood Heights REGISTERED NO.

CITY OF BALTIMORE: (No. Hazlett & Parkton ST., 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Moser

(a) RESIDENCE NO. Hazletts Parkton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.

PARENTS

10 NAME OF FATHER Ludwig Moser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Selmeckebier

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Theodor Selmeckebier (Address) Hazletts Parkton Md.

15 Filed APR 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to apl 24, 1922, that I last saw her alive on apl 24, 1922, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri + Ovarian Cyst

about 1 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 15/21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert H. Mifflin, M. D.

, 19 (Address) No 1076 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 26 1922
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St.

N. B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63747

CERTIFICATE OF DEATH.

D 63747

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Goldfoos

(a) RESIDENCE NO. 115 Aisquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto St

15 Filed APR 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 30th, 1922, to April 25th 1922

that I last saw him alive on April 24th 1922

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) chronic nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Jacob L Wessner, M. D.

4-26, 1922 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 4/26 1922

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63748

D 63748

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bruce Digges.

(a) RESIDENCE. NO. Montgomery Co. Md. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Digges.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Office

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Warden

15 APR 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April - 22 1922

17 I HEREBY CERTIFY, That I attended deceased from July - 10 1921, to April - 22, 1922, that I last saw him alive on April - 22, 1922, and that death occurred, on the date stated above, at 6:05 p. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

Pulmonary Tuberculosis ?

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (incipient)

(duration) yrs. 9 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William H. Silvertz, M. D.

4-23, 1922 (Address) Md. Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Baptist Cemetery Orange Va	4-27 1922

20 UNDERTAKER ADDRESS

Felix Bryan 102 E. Mulberry St

O. K. to issue should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63749

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 Craphurst Road St., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine B. Wallace WALLACE

(Residence in Baltimore: No. 11 Craphurst Road St.; 36 yrs., 6 mos., 11 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October (Month) 14 (Day), 1885 (Year)

7-AGE, 36 yrs. 6 mos. 11 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William H Clubb

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Retue

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Wallace

(Address) 3618 Old York Road

15- APR 26 1922 ROBERT R. KRAUTER, Registrar.

Filed....., 191.... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 25 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/22/1922, to 4/25/1922, that I saw her alive on 4/21/1922, and that death occurred, on the date stated above, at 6:10 a.m.

The CAUSE OF DEATH* was as follows:

1. Myocardial Insufficiency

2.

3.

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(Duration) ....yrs. ....mos. ....da.

(Signed) H. N. Freeman M. D.

....., 191... (Address) 2621 N Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery | DATE OF BURIAL, April 28, 1922.

20-UNDERTAKER George Schilling & Sons | ADDRESS 1116 E Monument St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Taylor

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63750

CERTIFICATE OF DEATH.

90 D 63750

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N. Carey St ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Elizabeth Taylor

(Residence in Baltimore: No. 504 N. Carey St. 72 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Femal

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1847.
(Month) (Day) (Year)

7-AGE 75 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Lorenz Dow Taylor

11-BIRTHPLACE OF FATHER (State or Country), Balt md

12-MAIDEN NAME OF MOTHER Elizabeth M Blair

13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D J S Bowers

(Address) 101 Washington Balto City

15- ROBERT R. KRAUTER

Filed APR 26 1922 Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 25, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 13 1922, to April 25 1922, that I saw h[illegible] alive on May 25 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 3 mos.....ds.

CONTRIBUTORY (Secondary) Mitral Insufficency

(Duration) yrs. 1 mos.....ds.

(Signed) John A Evans M. D.

April 27, 1922 (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, April 28, 1922

20-UNDERTAKER H S Marshall 3539

ADDRESS Lake Road

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63751 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63751

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... St. 3 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carmela Febbo -

(a) RESIDENCE. NO. 919 Fawn St. St., ... Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 10 yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	married -

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Dominic Febbo -

6 DATE OF BIRTH (month, day, and year) 2/22, 1895 -

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy -

PARENTS

10 NAME OF FATHER Geo. Ridini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy -

12 MAIDEN NAME OF MOTHER Ann Coffee -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy -

14 Informant University Hospital - (Address)

15 Filed APR 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25- 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-16- 1922, to 4-25-22, 19....., that I last saw her alive on 4-25-22, 19....., and that death occurred, on the date stated above, at 11.15 P.M.

The CAUSE OF DEATH* was as follows:

Acute cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) appendicitis -

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-16-22 -

Was there an autopsy? No

What test confirmed diagnosis? Routine -

(Signed) J. R. O Rourke, M. D.

, 19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	4/27 1922
20 UNDERTAKER Jones & Jonson	ADDRESS 1214 Greene

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

William Holston McKee

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63752 HEALTH DEPARTMENT—CITY OF BALTIMORE

160 D 63752

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4019 Roland Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Holston McKee

(a) RESIDENCE. NO. 4019 Roland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 19-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER R. Wm McKee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland Ohio

12 MAIDEN NAME OF MOTHER Carrie C. Holston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant R. Wm McKee (Address) 4019 Roland Ave.

15 Filed APR 26 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to April 26, 1922, that I last saw him alive on April 26, 1922, and that death occurred, on the date stated above, at 4.45 A.M.

The CAUSE OF DEATH* was as follows:

Acute Intoxication

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Davis, M. D.

4-26 1922 (Address) 800 N 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 26 1922

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Hall Rd.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63753

CERTIFICATE OF DEATH

179 D 63753

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 827 Light St. 22 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lloyd

(Residence in Baltimore: No. 827 Light St. 84 yrs. 9 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: June (Month) 30 (Day), 1837 (Year)

7-AGE: 84 yrs. 9 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Detective B&O R.R.

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Thomas Lloyd

11-BIRTHPLACE OF FATHER (State or country): Wales

12-MAIDEN NAME OF MOTHER: Rachael Watkins

13-BIRTHPLACE OF MOTHER (State or country): Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John D. Lloyd

(Address) 827 Light St

Filed APR 28 1922

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 25 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1922 to April 25 1922

that I saw h[illegible] alive on April 25, 1922

and that death occurred, on the date stated above, at 2.05 p m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. 1 mos. ..... ds

Contributory (SECONDARY) Senile Debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

April 25, 1922 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: April 28, 1922

20-UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63754

CERTIFICATE OF DEATH.

129 D 63754

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Druid Hill ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Harris

(a) RESIDENCE. NO. 1719 Druid Hill ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE: 68 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): L

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va —

PARENTS

10 NAME OF FATHER: Billie Prosser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Agnes Prosser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Katherine Johnson

(Address): 1719 Druid Hill ave

15 Filed APR 26 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 1922 to Apr 23 1922

that I last saw h[illegible] alive on Apr 23 1922

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

ac Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Ac Parenchymatous Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinary Examination

(Signed) [illegible] Short, M. D.

4/24/1922 (Address) 1812 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: In Auburn Cem't — DATE OF BURIAL: 4-26 1922

20 UNDERTAKER: George H. Holland — ADDRESS: 1631 Druid Hill ave

N. B.—WHITE PAPER. All questions must be carefully answered. If any cannot be answered, the reason should be stated. EXACT information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably chronic nephritis with repeated acute attacks & other abnormal condition

Antonas Nakossas

D 63755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 74-09

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonas Nakoosas.

(Residence in Baltimore: No. 639 W. Lombard St. 41 20 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 4 (Day), 1894 (Year)

7-AGE, 28 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 080

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, John Nakoosas

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celia Nakoosas

(Address) 639 W Lombard St

15- APR 26 1922 Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 24 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy 4 days

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. R. Grunert M. D. (Coroner.)

4-26, 1922 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemetery	4/27/22, 19....

20-UNDERTAKER	ADDRESS
Geo. J. Ruth	1235 Hanford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

63756 5/7 Col'd

HEALTH DEPARTMENT—CITY OF BALTIMORE

5/007

11 D 63756

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 7 WARD)

2-FULL NAME Edward Stokes.

(a) RESIDENCE No. 1534 E. Eager St ST., City. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored ~~White~~

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Sept 5, 1921.

7 AGE — Years: — Months: 7 Days: 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. boy

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer: —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James Stokes.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Agnes Grant

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed APR 26 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24. 1922. to April 24. 1922. that I last saw him alive on April 24. 1922 and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Influenza meningitis

(duration) 0 yrs. 0 mos 14 ds.?

CONTRIBUTORY (Secondary) otitis media, acute

(duration) 0 yrs. 0 mos. 14 ds.?

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Finding influenza bacilli in ~~spinal fluid~~

(Signed) TB Gay, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: April 26 1922

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1725 Ashland Ave

N. B.—WRITE PLAINLY. WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63757 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 63757

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

2-FULL NAME William Wilson

(a) RESIDENCE NO. 237 S. Spring St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1873

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 APR 26 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1922 to April 24, 1922.

that I last saw him alive on April 24, 1922.

and that death occurred, on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Syphilis, Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted 3 years.
If not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. A. McKay M. D.

4/25/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Valley Cemetery

DATE OF BURIAL April 27 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63758

D 63758

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 11 WARD)

2-FULL NAME Mamie Newman

(a) RESIDENCE. NO. 1132 E. McCullough St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Holman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant Hospital Records, (Address) Municipal Hospital

15 Filed APR 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11, 19 22 to April 25, 19 22

that I last saw h er alive on April 24, 19 22

and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma of uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Litt Brumback, M. D.

4/25/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn

DATE OF BURIAL Apr 28 1922

20 UNDERTAKER R L Gross ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 63759
1 PLACE OF DEATH

CERTIFICATE OF DEATH

1 29 12 D 63759
REGISTERED NO. C

CITY OF BALTIMORE (No. 2835 St Paul St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME O. Fred. Shamberger

(Residence in Baltimore: No. 2835 St Paul St. St.: 4 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June 24, 1877 (Month) (Day) (Year)

7-AGE: 44 yrs. 10 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Bank Pres 086
(b) General nature of industry, business, or establishment in which employed (or employer): President

9-BIRTHPLACE (State or country): Parkton, Md

PARENTS

10-NAME OF FATHER: Daniel Shamberger

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Martha Smith

13-BIRTHPLACE OF MOTHER (State or country): Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Shamberger

(Address) 2835 St Paul St

15. Filed APR 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 25th, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1922 to April 25 1922 that I saw h[illegible] alive on April 25th, 1922 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Parenchymatous)

..... (Duration) Unknown yrs. ..... mos. ..... ds

Contributory (SECONDARY) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jefferies Bruce M. D.

Apr. 26, 1922 (Address) 2844 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Apr. 27, 1922

20-UNDERTAKER: George Schwab

ADDRESS: 2101 Eutaw Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63760

D 63760

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Baby Galloway.

(a) RESIDENCE NO. 903 Shuter ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Prefix to any information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 18, 1922

7 AGE — Years — Months 2 Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Winfred Williams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Blanche Galloway.

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Maryland.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed APR 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20, 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1922 to Apr. 20, 1922 that I last saw her alive on Apr. 20, 1922 and that death occurred, on the date stated above, at 1:45 P.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. H. Cattrall, M. D.

(Address) Johns Hopkins Hospital. 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS APR 20 1922

Per. Wm. R. WOODALL

Spec.—1-10-21—M&T—1500 Bks.

155063 D 63761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 63761

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. .....

CITY OF BALTIMORE: (No. " " " ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Simmonson City.

(a) RESIDENCE NO. 630 S. Wallas St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced (HUSBAND of) (or) (WIFE of): ?

6 DATE OF BIRTH (month, day, and year): Feb. 28, 1845

7 AGE: Years 77 Months 1 Days 24. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 987

(c) Name of employer: ( )

9 BIRTHPLACE (city or town) (State or country): Sweden.

PARENTS

10 NAME OF FATHER: Jonas Simmonson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden.

12 MAIDEN NAME OF MOTHER: Marie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 File APR 26 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922. to April 21, 1922.

that I last saw him alive on April 21, 1922.

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? None.

(Signed) Chas. H. Dorsey, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health, Per. Wm. E. Woodall

ADDRESS APR 2 1922

Spec.—1-10-21—M&T—1500 Bks.

D 63762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63762

CERTIFICATE OF DEATH.

X 84

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2-FULL NAME Luther Edwin Gray

(a) RESIDENCE NO. Russelville ST. WARD Alabama

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	34	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Mary McCrele

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed APR 26 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21st, 1922 to April 26th, 1922, that I last saw h[illegible] alive on April 26th, 1922, and that death occurred, on the date stated above, at 7:20 A. m.

The CAUSE OF DEATH* was as follows:

brain tumor

(duration) yrs. 6 mos ds

CONTRIBUTORY (Secondary) operation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 22./22

Was there an autopsy? No

What test confirmed diagnosis? operation.

(Signed) Jay McEar, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sheffield ala

DATE OF BURIAL April 26, 1922

20 UNDERTAKER Joseph ahrens

ADDRESS 221 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63763

CERTIFICATE OF DEATH.

31 D 63763

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 819 W^m St ST., 22 WARD)

2-FULL NAME Mrs. Kane

(a) RESIDENCE NO. 819 W^m St ST., William WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE INFORMATION ASKED FOR MUST be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63764

CERTIFICATE OF DEATH.

141

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. South Balto. Gen. Hospital ST.: 2V WARD)

2-FULL NAME Mrs. Nora O'Connor

(a) RESIDENCE. NO. 20 E Hill St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin J O'Connor

6 DATE OF BIRTH (month, day, and year) Apr 30 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Martin Ruth

(Address) 2511 Eastern ave

15 APR 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr-26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 26, 1922, that I last saw her alive on April 26, 1922, and that death occurred, on the date stated above, at 4:40 A m.

The CAUSE OF DEATH* was as follows:

Prolapse of uterus (complete)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 12, 1922

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Pokorny, M. D.

, 19 (Address) South Balto Gen Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Apr 28 1922
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—This [illegible] be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. AGE should

Spec.—5-19-13—M. & T.—500 Blks.

D 63765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63765

CERTIFICATE OF DEATH.

179

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Brown

(Residence in Baltimore: No. 1632 E. Monument St.; Life yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar. ..., 1888
(Month) (Day) (Year)

7-AGE, 34 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Laura Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Brown

(Address) 1632 E. Monument St

15-

APR 26 1922

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 24 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/20 1922, to 4/24 1922, that I saw her alive on 4/23 1922, and that death occurred, on the date stated above, at 5.20 A.m.

The CAUSE OF DEATH* was as follows:

General Toxemia

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis and Pyorrhea

(Duration) ... yrs. 1 mos. ... ds.

(Signed) R. J. Young M. D.

4/25, 1922 (Address) 1129 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, 4/27, 1922

20-UNDERTAKER Samuel Hendley & Bro

ADDRESS 375

N.B.—Every item of information should be carefully supplied. AGE should be given in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63766

CERTIFICATE OF DEATH.

74-001 D 63766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Olive ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bennett

(Residence in Baltimore: No. 1118 Olive St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. (Month) 14 (Day), 1874 (Year)

7-AGE, 47 yrs. 5 mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Bennett

(Address) 1118 Olive

15-

Filed ....., 191.....

Robert F. Harrison, Registrar.

APR 26 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 24 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 23 1922, to Apr 24 1922, that I saw him alive on Apr 24 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William E. Burton M. D.

Apr. 26, 1922 (Address) 762 Delphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Hill Ave

DATE OF BURIAL, Apr. 26 1922

20-UNDERTAKER Samuel Handy Jr.

ADDRESS 1118 Biddle

NR 2—Every item of information should be carefully supplied. AGE should be given EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63767

CERTIFICATE OF DEATH.

D 63767

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 Binney St ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda A. Rode

(a) RESIDENCE NO. 929 Binney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Rode

6 DATE OF BIRTH (month, day, and year) May 16, 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	62	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Aug. Masgaeth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) NotKnown

14 Informant Otto Rode

(Address) 929 Binney St.

15 Filed ....., 19.... Registrar

APR 26 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1922 to April 25, 1922, that I last saw her alive on April 25, 1922 and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis Deformans

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H B Tetlow, M. D.

4/26, 1922 Address 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL April 28 1922

20 UNDERTAKER Zickler + Zickler

ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE RESERVED. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63768

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 63768

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

2-FULL NAME Mary Ales.

(a) RESIDENCE. NO. Preston Valley Ho. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anthony Ales

6 DATE OF BIRTH (month, day, and year) 1846 ~~1846~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Frank Morarski

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence.
(Address) Preston Ave.

15 Filed APR 26 1922 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1922

17 I HEREBY CERTIFY, That I attended deceased from No Record. 19.. to ..... 19..

that I last saw h[illegible] alive on April 23 1922,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Warner, M. D.

April 24 1922 (Address) 1133 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	April 27 1922
20 UNDERTAKER	ADDRESS
Stephen J. Kulkowski	1005 Hanover

B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should be careful in stating information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 63769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63769

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2600 Hudson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Kawecki

(Residence in Baltimore: No. 2600 Hudson St.; 40 yrs.; mos.; ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH. July — 1860 (Month) (Day) (Year)

7-AGE. 63 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE. (State or Country). Poland.

PARENTS.

10-NAME OF FATHER. Lawrence Kawecki

11-BIRTHPLACE OF FATHER. (State or Country). Poland.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Kawecki

(Address) 2600 Hudson

15- Robert P. Harrison,

Filed ....192.... Burial Permit Clerk. Registrar.

APR 26 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr 24 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) ....yrs. ....mos. 2 ds.

(Signed) W. E. Gilbert M. D.

(Coroner)

April 25 192.... (Address) 1436 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	4/27 1922

20-UNDERTAKER. Wm. F. Jackson ADDRESS 1618 East

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Burrows)

D 63770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2634 Fehlman ave REGISTERED NO. 100

CITY OF BALTIMORE: (No. Municipal ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Burrows

(a) RESIDENCE No. 2634 Fehlman ave ST. 20th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Burrows

6 DATE OF BIRTH (month, day, and year): Oct 10-1857

7 AGE: Years 64 | Months 6 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (City or town) (State or country): Talbot County Md

PARENTS

10 NAME OF FATHER: James Ennis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot County Md

12 MAIDEN NAME OF MOTHER: Cordilla Edge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot County Md

14 Informant: Tova E. Nelson

(Address) 2634 Fehlman Ave

15 Filed ....., 19.... Registrar: Robert F. Harrison, Burial Permit Clerk.

PR 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to April 10, 1922,

that I last saw h— alive on April 9th, 1922,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(Had large adenoma of thyroid 20 yrs duration)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Dilatation of heart

(duration) yrs. mos. 12 hrs ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Bermuda A. Nelson, M. D.

April 12, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: April 27 1922

20 UNDERTAKER: F. D. Weyforth

ADDRESS: 2256 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63771

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 944 S. Clinton St., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mackowiak

(a) RESIDENCE NO. 944 S Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) Homework

(c) Name of employer At Home.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Micheal Mackowiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Zwiackowa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Mackowiak.

(Address) 944 S. Clinton St

15 Filed ..... 19 .... Registrar

APR 26 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922, to April 24, 1922, that I last saw h.. alive on April 24, 1922, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

acute nephritis

(duration) yrs. ~~mos.~~ 18 ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Janiszewski M. D.

4/25, 1922 (Address) 2431 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 4/27 1922

UNDERTAKER William Falkowski

ADDRESS 108 Eastern Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—1-10-21—M&T—1500 Bks.

D 63772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63772

CERTIFICATE OF DEATH.

X 118,001

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 7 WARD)

2-FULL NAME Helen Gilbert

(a) RESIDENCE NO. Willington S. C. ST., WARD Willington S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Music teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S Carolina

PARENTS

10 NAME OF FATHER Jas McMeehan

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Katherine Faulkner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Robert P. Harrison, Registrar

APR 26 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 26, 1922, that I last saw her alive on April 26th, 1922 and that death occurred, on the date stated above, at 8 55/60 a.m.

The CAUSE OF DEATH* was as follows:

Diaphragmatic hernia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar. 25, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. Sidney Burwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Willington S.C. DATE OF BURIAL 4/26/22

20 UNDERTAKER H. E. Bryhal Asst. N. Tody ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63773

CERTIFICATE OF DEATH.

179 D 63773

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 N. Milton Ave. ST.; 6th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Bowen Rauch

(a) RESIDENCE. No. 101 N. Milton Ave. ST., 6th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma E. Rauch

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 109 Pilots

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pilots Association

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Henry Rauch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Jane Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Ida M. (illegible) Rauch.
(Address) 101 N. Milton Ave

APR 26 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Apl 1, 1921, to April 24, 1922, that I last saw h in alive on April 24, 1922, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intercurrent

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~out Town~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. Paducci, M. D.

, 19 (Address) 2729 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	4/28/22

20 UNDERTAKER ADDRESS

H. E. Kugler & Son 1611 Bridge

R.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63774

CERTIFICATE OF DEATH.

81 D 63774

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 N Lakewood St., do Ward)

2-FULL NAME Anna Knight

(a) RESIDENCE NO. 406 N Lakewood St. and Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W Knight

6 DATE OF BIRTH (month, day, and year) Oct 16-1853.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Shoben Stumbaur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward H Knight

(Address) 536 N Gay st

15 APR 26 1922, 19 Robert F Kaffenburgh, Registrar

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2 1921 to Apr. 25 1922, that I last saw her alive on Apr. 22 1922, and that death occurred, on the date stated above, at 3 30 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J E Rivenock M. D.

4-26 1922 (Address) 1531 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL April 27 1922

20 UNDERTAKER Jno C. Muller

ADDRESS 2334 Jefferson St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63775

CERTIFICATE OF DEATH.

33 D 63775

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5254 Maine St. ST., Arlington WARD)

2-FULL NAME Sadie E. Thomas

(a) RESIDENCE NO. 5254 Maine St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in stating the cause of death, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Cornelius Thomas

6 DATE OF BIRTH (month, day, and year): June 30-1857

7 AGE — Years: 64 — Months: 9 — Days: 26 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER: William Robouet

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Steinaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John F. Thomas

(Address): Stuteford Md.

15 Filed Robert P. Harrison, Registrar

PR 26 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/5, 1922, to 4/25, 1922,

that I last saw h[illegible] alive on 4/25, 1922,

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Apostatic pneumonia

(duration) yrs. mos. 9-5 ds.

18 Where was disease contracted if not at place of death? At Home Whitford Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Henry C. Russell, M. D.

, 19 (Address) 3902 Greenland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: April 27 1922

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Rd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 174

D 63776

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 St. Paul St ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Little

(a) RESIDENCE. NO. 816 St. Paul St ST., WARD. Parkton Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Little

6 DATE OF BIRTH (month, day, and year) May 16, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Parkton Md.

PARENTS

10 NAME OF FATHER Charles Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Miranda Hutchens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John Mayo Little Mt. Royal Apts.

15 Filed 19 Robert P. Harrison, Registrar

APR 26 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 19 22, to Apr. 21, 19 22, that I last saw him alive on Apr. 23, 19 22, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arterio-Sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure - urinalysis

(Signed) G. H. Wolterenbeck, M. D

Apr. 26, 19 22 (Address) 1210 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stabler's Cem. Parkton, Md

DATE OF BURIAL April 28, 19 22

ADDRESS 1258 Park Ave.

20 UNDERTAKER E. LeRoy Stiffler

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63777

CERTIFICATE OF DEATH.

X 101-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur R. Barnett

(a) RESIDENCE. NO..... Severn Maryland ST., ... WARD. Severn Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work student.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland-

PARENTS

10 NAME OF FATHER A. H. Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Cole.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant University Hosp. Records.

(Address)

15 Filed Apr 25 19 22 Robert J. Larrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 25 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25 1922

17

I HEREBY CERTIFY, That I attended deceased from 3/14 19[illegible], to 4/25 19[illegible], that I last saw him alive on 4-25. 19 22, and that death occurred, on the date stated above, at 11.10 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Empyema with resection sept caries (duration) yrs. mos. 42 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/15/22

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) K. B. Jones M. D.

(Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery Baltimore Md

DATE OF BURIAL Apr 28 1922

20 UNDERTAKER E. LeRoy Stiffler

ADDRESS 1252 North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for drainage of empyema. No further history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63778

CERTIFICATE OF DEATH.

D 63778

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3130 Elliott St.; 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michalina Kordowska

(a) RESIDENCE. No. 3130 Elliott St. ; ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos Kordowska

6 DATE OF BIRTH (month, day, and year): Jan 12 1850

7 AGE — Years: 71 — Months: 3 — Days: 12 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): housewife

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Russian Poland

PARENTS

10 NAME OF FATHER: Wanzen Kordowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Jos. Kordowski
(Address): 3130 Elliott St.

15 Filed: Robert P. Harrison, Registrar
Burial Permit Clerk.

APR 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1922, to April 24, 1922;
that I last saw h[illegible] alive on April 24, 1922,
and that death occurred, on the date stated above, at 12.30 P. m.
The CAUSE OF DEATH* was as follows:

Exhaustion from general peritonitis
4 yrs

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Strangulated hernia

gangrene (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [signature] right, M. D.

4/25, 1922 (Address) 614 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Antrim Mem Park — DATE OF BURIAL: Apr 27 1922

20 UNDERTAKER: Hahn & Stadkowski — ADDRESS: 1000 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63779

REGISTERED NO. 4117

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie V Smith

(a) RESIDENCE. NO. Fullerton Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willis E. Smith

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	—	—	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John T Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary A Talley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Hospital Records.

15 Filed APR 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to April 26, 1922, that I last saw her alive on April 26, 1922, and that death occurred, on the date stated above, at 8:35 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Hepatitis

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of April 20 1922

Was there an autopsy? No

What test confirmed diagnosis? X-Ray Broadrup. M. D.

(Signed) (Address) University Hospital, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chester Dale Md

DATE OF BURIAL: 4/29 1922

20 UNDERTAKER: Jones & Jonson

ADDRESS: 14 N Green St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL should be carefully supplied. AGE should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Md. Dec. 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63780

CERTIFICATE OF DEATH.

84

D 63780

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 9 WARD)

2-FULL NAME Mary E. Mitchell

(a) RESIDENCE NO. 1643 Mont Ellis St. City

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ (or) WIFE of: Alexander Mitchell (Husband)

6 DATE OF BIRTH (month, day, and year): March 27 1874

7 AGE: Years 48 Months — Days 29. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife 937

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Anton Kechil.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece.

12 MAIDEN NAME OF MOTHER: Eliza O'Connor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Friends.

15 APR 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24. 1922. to April 25. 1922.

that I last saw her alive on April 25 1922.

and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Shock —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) operation on cerebellum

Brain tumor (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of 4-24-22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Warfield M Firor, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: April 27 1922

20 UNDERTAKER: H. Sander Sons ADDRESS: 1710 Park Av.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

154473
D 63781

100-901
D 63781

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.
" " " ST., 10 WARD)
CITY OF BALTIMORE: (No. .....

2-FULL NAME Margaret Clark.

(a) RESIDENCE NO. 1017 Forrest St. City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ James & Mary Clark. (Parents)

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years | 1 Month | 14 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child. 000
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, "

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Records

15 APR 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25 1922, to April 26 1922, that I last saw her alive on April 26 1922, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

TBW

Bronchopneumonia (duration) ... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Dehydration (duration) ... yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Wreh M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 4-27 1922

20 UNDERTAKER J. A. Moran ADDRESS 3am E Baltos.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (morely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Wack states dehydration
prob'ly due ist. to child being
dehydrated prior to entrance
w/hosp't 2nd. to
vomiting. No further
history

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63782

REGISTERED NO. D 63782

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Hillman ST., 9 WARD)

2-FULL NAME Mary C. Connelly

(a) RESIDENCE NO. 1307 Hillman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward J. Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A. O'Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Edward J. Connelly
(Address) 1307 Hillman St

15 APR 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26' 1922

17 I HEREBY CERTIFY, That I attended deceased from 4,10 ,191 , to 4,26 ,1922.

that I last saw h alive on 4,26 ,1922,

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Measles, Bronchitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 907 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Apr. 28 1922

20 UNDERTAKER Henry Hoeck Son

ADDRESS 1304 E Lanvale

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63783 HEALTH DEPARTMENT—CITY OF BALTIMORE 63783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 608 N. Carey St ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winfield Scott Amos

(Residence in Baltimore: No. 608 N. Carey St St; yrs., 61 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Aug Unknown 1860
(Month) (Day) (Year)

7-AGE, 61 yrs. Unknown mos. da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nurse. D48
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Aquilla Amos.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Isabelle McComas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R K West

(Address) 1711 St Paul St.

15- APR 27 1922 Filed....., 191... ROBERT. R. KRAUTER. Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 25, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secoadary) Arteriosclerosis

(Duration) 3 yrs.....mos.....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 26 1922 (Address) 2502 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	April 27 1922
20-UNDERTAKER	ADDRESS
Tom Heckrotte Sons	North & Pa

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63784

CERTIFICATE OF DEATH.

74-001 D 63784

N. B.—WRITE PLAINLY, WITH UNFADING INK. All questions must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. The Address should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Rear alley ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Jackson

(a) RESIDENCE NO. 922 Rear alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Jackson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anne Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eugene Jackson (Address) 922 Rear alley

15 Filed APR 27 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922, to April 26, 1922, that I last saw her alive on April 25, 1922, and that death occurred, on the date stated above, at 1.50 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy + Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D.S.W. Kennach, M. D.

4-26 1922 (Address) 28 Ensor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Apr 28 1922

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Union St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63785

CERTIFICATE OF DEATH.

47

D 63785

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3901 Roland Ave ST., 13 WARD)

2-FULL NAME Margaret J. Biggs

(a) RESIDENCE NO. 3901 Roland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Harry Biggs

6 DATE OF BIRTH (month, day, and year): Feb 23-1865

7 AGE: Years 57 Months 2 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Belfast (State or country) Ireland

PARENTS

10 NAME OF FATHER: John White

11 BIRTHPLACE OF FATHER (city or town) Belfast (State or country) Ireland

12 MAIDEN NAME OF MOTHER: Catherine Kearney

13 BIRTHPLACE OF MOTHER (city or town) Belfast (State or country) Ireland

14 Informant: Mr Harry Biggs (Address) 3911 Roland Ave

15 APR 27 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from August —, 1921 to April 27, 1922, that I last saw h~~e~~ alive on April 27, 1922, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left Breast

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver (duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1921

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. B. Norment, M. D.

4.27. 1922 (Address) 3877 Chelsea Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge DATE OF BURIAL: Apr 29 1922

20 UNDERTAKER: A S Marshall ADDRESS: 3539 Fallsd

Spec.—1 10-21—M&T—1500 Bks.

D 63786 HEALTH DEPARTMENT—CITY OF BALTIMORE 001

CERTIFICATE OF DEATH. 74 D 63786

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 Eutaw Place ST., 14 WARD)

2—FULL NAME Eliza Parker Rolph

(a) RESIDENCE NO. 1400 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J. Rolph

6 DATE OF BIRTH (month, day, and year) Oct 8. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Saml. R. Clayland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Macdonough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Rolph (Address) 1400 Eutaw Place

15 Filed APR 27 1922 19 F. E. Kehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1922

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to April 25, 1922, that I last saw her alive on April 25, 1922, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) ✓ yrs. ✓ mos 2 ds.

CONTRIBUTORY (Secondary) Senile Arteris sclerosis (duration) over 1 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry L. Ehrlich M. D.

Apr 26, 1922 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL April 27 1922

20 UNDERTAKER ADDRESS John Oursler 1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY as near as possible. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 63787

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63787

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4014 Pennhurst ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaline Bentley

(a) RESIDENCE NO. 4014 Pennhurst ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23-1848

7 AGE: Years 73 Months 5 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Morristown N. J.

PARENTS

10 NAME OF FATHER John V. Bentley

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER Caroline Dickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant Mrs. John C. Lewis (Address) 4014 Pennhurst ave

15 Filed APR 27 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1922 to April 25 1922 that I last saw h[illegible] alive on April 25 1922 and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

4/27, 1922 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morristown N. J. DATE OF BURIAL: April 28 1922

20 UNDERTAKER: John O. Mitchell ADDRESS 1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bettie 6. Dailey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63788 ✓

D 63788

CERTIFICATE OF DEATH.

No. 138

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST.: 1 WARD)

2-FULL NAME Mrs. Francis E. Dailey

(a) RESIDENCE. NO. 2737 Eastern Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. F. Dailey.

6 DATE OF BIRTH (month, day, and year) Mar. 20 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Humphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Cromwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hoss H. Pumphrey (Address) Brooklyn Md.

15 Filed APR 27 1922 Registrar John O. Mitchell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 1922, to Apr 26, 1922

that I last saw h.er alive on Apr 26, 1922

and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

Infection

~~Lung~~ Pneumonia and abdominal Abscess.

Duration: previous to admission? Since admission yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) abscess in abdomen

+pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? yes Date of Apr 13 1922

Was there an autopsy? no. clinical observations

What test confirmed diagnosis?

(Signed) Edward M. Hanrahan M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: April 28 1922

20 UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Fayette

N. B.—Facts called for should be carefully supplied. Age should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

First thought appendicial disease
Operation showed case
was broad ligament
abscess caused ruptured
Secondary peritonitis
and broncho pneumonia

Spec.—1-10-21—M&T—1500 Bks.

D 63789 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63789

CERTIFICATE OF DEATH. X44

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. " " " St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Biery

(a) RESIDENCE NO. Easton, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Biery (wife)

6 DATE OF BIRTH (month, day, and year) Dec 23-79

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42 yrs	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Biery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Thelia Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed APR 27 1922, 19 J. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 27, 1922, that I last saw him alive on April 27, 1922, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach ~~with abdominal metastasis~~

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Abdominal metastasis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Easton Md.

Did an operation precede death? Yes Date of April 21, 1922

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) P B Mac Crendy, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md. DATE OF BURIAL Apl 27 1922

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63790 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63790

CERTIFICATE OF DEATH. 185 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 4 Fulton St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Miss S. Elbena Challis

(Residence in Baltimore: No. 400 4 Fulton ave St.; yrs., 74 mos..... ds.)

N. B.—Every item of information should be carefully supplied. Exact statement of cause properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Dec (Month) 10 (Day) 1847 (Year)

7-AGE. 74 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Cincinnati O.

PARENTS.

10-NAME OF FATHER. Josiah Challis

11-BIRTHPLACE OF FATHER, (State or Country). New Hampshire

12-MAIDEN NAME OF MOTHER. Lidia Zoller

13-BIRTHPLACE OF MOTHER, (State or Country). New Hampshire

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ettie Cuddy

(Address) 400 N Fulton

15- FILED APR 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of R Hip

(Duration) ....yrs. ....mos. 16 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) ....yrs. ....mos. 10 ds.

(Signed) James M Preston M. D. (Coroner.)

April 27 1922 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, April 28 1922

20-UNDERTAKER, George J. Smith ADDRESS 1000 W Lafayette Ave

Due to fall

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill,* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D 63790~~ D 63791

CERTIFICATE OF DEATH.

90

D 63790

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2943 ½ Charles ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina E Kranz

(a) RESIDENCE. NO. 2943 ½ Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Kranz

6 DATE OF BIRTH (month, day, and year) May 14, 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jacob Fronce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Edna Kranz Gettier 2943 ½ Charles St

15 Filed APR 27 1922 J. E. Mehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1922, to April 25, 1922.

that I last saw h... alive on April 25, 1922.

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart

8 hours (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Ch. Myocarditis (duration) Unknown ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of c

Was there an autopsy? No

What test confirmed diagnosis? c

(Signed) Jeffries Beale, M. D.

4/26 1922 (Address) 2844-52 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 28 1922

20 UNDERTAKER George J. Smith ADDRESS 1000 W. Fayette St.

N. B.—WRITE PLAINLY, with ink. All items must be carefully supplied. AGE should be stated IMMEDIATELY after name of deceased. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Spec.—1-10-21—M&T—1500 Blks.

D 63792 HEALTH DEPARTMENT—CITY OF BALTIMORE ~~D 63791~~

CERTIFICATE OF DEATH.

3 | D 63792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Mc Culloh ST., 11 WARD)

2-FULL NAME Annie Goodman

(a) RESIDENCE NO. 1121 Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Goodman

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) D37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Brandt Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant George Goodman

(Address) 1121 Mc Culloch st

15 Filed APR 2 1922 J E Mehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 22, 1922, to Apr 26, 1922, that I last saw h[illegible] alive on Apr 25, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Chest findings

(Signed) Chas Wm Frey M. D.

4/26, 1922 (Address) 1928 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ivy Hollaway Va. Hollaway Station

DATE OF BURIAL Apr-28 1922

20 UNDERTAKER Edward Ruggold

ADDRESS 1463 Carey st

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. AGE should be stated in years. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63793 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 90 D 63793

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Calvin ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Matthews

(a) RESIDENCE. NO. 108 Calvin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lloyd Matthews

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lloyd Matthews (Address) 108 Calvin St

15 Filed APR 2 1922 F. E. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 23 1922, to Apr 25 1922, that I last saw h alive on Apr 25 1922, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Cystic Tumor of Pelvis Uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Crutchfield Jones, M. D.

, 19 (Address) 1418 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr-27 1922
20 UNDERTAKER	ADDRESS
Edward Ringgold	1463 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. All information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1140 Forman St.: 15 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Rosell

(a) RESIDENCE. No. 1140 Forman St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 34 yrs — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mardie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Minnie Gray 1140 Forman St

15 Filed APR 27 1922 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25 1922

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1922, to 4/25, 1922, that I last saw h— alive on 4/25, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

a Phthisis Pulmonalis

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 15-32 Mount St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhardt, M. D.

, 19 (Address) 2139 Druid a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 28 1922
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 63795

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63795

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 Carlyle av. ST., 15 WARD)

2-FULL NAME Ellsworth E. Cromwell

(a) RESIDENCE NO. 3313 Carlyle Av. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 30/1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jacob E Cromwell

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Ida Eppler

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Jacob E Cromwell (Address) 3313 Carlyle av.

15 Filed APR 27 1922 J. H. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch. 9th, 1922, to Apr. 26 1922, that I last saw him alive on Apr. 26th, 1922, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Valvular dis. of heart with dilatation & Oedema of lungs

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) yrs. mos. 47 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Percussion

(Signed) C. C. Smith, M. D.

4/26 1922 (Address) 1600 W Mork Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: Apr. 29 1922

20 UNDERTAKER: H. M. Cook — ADDRESS: A+G Balto.

N. B.—WRITE PLAINLY. ALL information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63796

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 | D 63796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3525 Eutaw Ave ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion B Scott

(Residence in Baltimore: No. 3525 Eutaw Ave St.; 6yr yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, June (Month) 10 (Day), 1889 (Year)

7-AGE, 32 yrs. 10 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Charles G Turner

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan H McCullen

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J A Scott

(Address) 56 Reade St. N.Y.C.

15- APR 27 1922

Filed ....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/20 1922 to 4/26 1922 that I saw h[illegible] alive on 4/26/22, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Uremia Endocarditis

..... (Duration) ... yrs. ... mos. 4 ds.

(Signed) Edward A Turner M.D.

4/27, 1922. (Address) 1522 Harlem

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, 4/29, 1922

20-UNDERTAKER Williams Coale ADDRESS 502 E Wash.

N.B.—Every item of information should be given as far as possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63797

CERTIFICATE OF DEATH.

89 D 63797

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2408 W Balto ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia A Smith

(Residence in Baltimore: No. 2408 W Baltimore St.; ~~1~~ yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct (Month) 25 (Day), 1844 (Year)

7-AGE, 77 yrs. 6 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER christ Konig

13-BIRTHPLACE OF MOTHER (State or Country), Baltic md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Smith

(Address) 2408 W Balto St.

15- APR 27 1922 Filed ..... J E Wilson Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25 1922, to April 26 1922, that I saw her alive on April 25 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Hall M. D.

4-26, 1922 (Address) Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, 4-28, 1922

20-UNDERTAKER Robert Brookdale

ADDRESS Catonsville Hollins

N. B.—Every item of CAUSE OF DEATH in plain terms, so that it may be properly classified. All important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63798

D 63798

X 45

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH Church Home and Infirmary ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. .....

2-FULL NAME Albert Crawford

(a) RESIDENCE NO. ..... Winfield Md. ST., ... WARD Winfield Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) Winfield, Md.
(State or country)

PARENTS

10 NAME OF FATHER Francis A. Crawford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) /

14 Informant Laura Dixon
(Address) Dixon Post Off.

15 Filed APR 24 1922, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922, to April 27, 1922, that I last saw him alive on April 27, 1922, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted, if not at place of death? ?

Did an operation precede death? Yes Date of April 26, 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Caycharn Lauretta ..., M. D.

..., 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery Taylorsville Cem

DATE OF BURIAL 4/30/22

20 UNDERTAKER C M Waltz

ADDRESS Winfield Md

Information should be carefully supplied. Age should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. SPECIAL ATTENTION is very important.

Annie Sykes 185 D 63799

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63799

CERTIFICATE OF DEATH

X Gossard Coroner

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No Lombard St. Greene WARD 4)

2-FULL NAME Annie Sykes

(a) RESIDENCE. NO. Pikesville, Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? 60 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Sykes

6 DATE OF BIRTH (month, day, and year) May 10 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany -

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Kreitzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Univ. Hospital Records

15 Filed APR 27 1922 E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-4-22, 19..., to 4-25-22 19..., that I last saw her alive on 4-25-22, 19..., and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Fractured Right Femur (Over)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Senility -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) W. B. Jones, M. D.

4/25 19 22 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 716 Oliver Roslyn

DATE OF BURIAL 4/27 192

20 UNDERTAKER William Cook

ADDRESS 502 E North

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Case in which fracture of femur was incurred was done, by stumbling down a small flight of steps in his home.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Stevens

D 63800 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63800

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 415 S. Vincent St. REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore ST.: 19 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Stevens.

(a) RESIDENCE. NO. 415 Vincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Harry Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) m. 1.

12 MAIDEN NAME OF MOTHER Mary Peck. m. 2.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry Stevens. (Address) 415 S. Vincent St.

15 Filed APR 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1922

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to April 25, 1922, that I last saw him alive on April 25, 1922 and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis.

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum

(Signed) Raymond C. Ellis, M. D.

April 25, 1922 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western cemetery	Apr 28 1922

20 UNDERTAKER	ADDRESS
Henry H. Witzke	1531 W. Lombard

N. B.—Write plainly. All answers should be carefully supplied. Any omission or mistake in information should be carefully supplied. Any omission or mistake in information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED

(Augusta Beyers) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63801

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH University Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Augusta Beyers -

(a) RESIDENCE. NO. 2348 Stockton ST - ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married -

5a If married, widowed, or divorced (or) WIFE of Chas J Beyers -

6 DATE OF BIRTH (month, day, and year) Aug. 16. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8.	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany ?

12 MAIDEN NAME OF MOTHER ? Sickell -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany. ?

14 Informant University Hospital -

(Address)

15 Filed Robert P. Harrison, Registrar

APR 27 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 25 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-24-22, 19, to 4-25-22, 19, that I last saw her alive on 4-25 22, 19, and that death occurred, on the date stated above, at 1 55 P m.

The CAUSE OF DEATH* was as follows:

Impacted Stock -

3 hrs - (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Biliary Passages (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-25-22

Was there an autopsy? No

What test confirmed diagnosis? Roentgen

(Signed) Thomas Reese, M. D.

4-25 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL 4 - 28 1922

ADDRESS

20 UNDERTAKER Wm. Chas. A. G. Rohde Funeral Co.

Inf. should be carefully supplied. Any mistake may be properly classified. Exact information should be carefully supplied, so that it may be permanent. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be permanent. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63802

D 63802

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S Bond ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Przewozni

(a) RESIDENCE. No. 606 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) APRIL 26 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Przewozni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Teresa Kuciah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) John Przewozni 606 S Bond

15 Filed Apr 27 1922 [illegible], Registrar

APR 27 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APRIL 27 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/27, 1922, to 4/27, 1922, that I last saw h[illegible] alive on 4/27, 19..., and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia Contributory Heart failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) H. J. Wainright, M. D.

4/17, 1922 (Address) 1623 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: APRIL 28 1922

ADDRESS

20 UNDERTAKER John M Weber 1803 Bank

N. B.—WRITE PLAINLY. All items should be carefully supplied. Age should be given in years, months and days. Exact information should be carefully classified. Age should be given in years, months and days. Exact information

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63803

CERTIFICATE OF DEATH.

3 1 D 63803

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 215 N. Central Ave St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eddie Hardy

(Residence in Baltimore: No. 215 N. Central Ave St.; 4 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	colored	Married

6-DATE OF BIRTH Sept 1, 1900
(Month) (Day) (Year)

7-AGE, 21 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Coal Yard

9-BIRTHPLACE, (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, William Johnson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Susie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Johnson

(Address) 215 N. Central Ave

15- Filed APR 28 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 26, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 24 1922, to April 26 1922, that I saw h in alive on April 26 1922, and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Richard C. Eveleigh jr. M. D.

April 26, 1922 (Address) 157 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Auburn St | DATE OF BURIAL, April 28, 1922

20-UNDERTAKER J. G. Brown & Son | ADDRESS

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63804

D 63804

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 S. Linwood Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel B. Latham

(a) RESIDENCE NO. 921 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie G. Latham

6 DATE OF BIRTH (month, day, and year) Jan. 7-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3.	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer). Spedden Shipbuilding Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert H. Latham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Meredith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bessie G. Latham

(Address) 921 S. Linwood Ave

15 Filed APR 28 1922 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1922, to April 26, 1922, that I last saw h— alive on April 26, 1922, and that death occurred, on the date stated above, at 5.05 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) W B Tillotson M. D.

(Address) 315 N. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester Ave. Chestertown Md

DATE OF BURIAL April 29 1922

20 UNDERTAKER Lilly & Zeiler

ADDRESS 402 S. Wolfe St.

N. B.—Write plainly. All information should be carefully supplied. Any item may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63805

CERTIFICATE OF DEATH.

161-901 D 63805

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3927 E. Lombard St. ST., 76 WARD)

2-FULL NAME Louisa Kroll.

(a) RESIDENCE NO. 3927 E. Lombard St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Kroll.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Lillian Cuomo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Frank Kroll
(Address) 3927 E. Lombard St.

15 Filed APR 28 1922 ROBERT R. KRAUTER, Registrar of Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1922, to April 26, 1922, that I last saw h[illegible] alive on April 26, 1922, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Maxwell Mayo M. D.

4/27/1922 (Address) 3116 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL April 28 1922

UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—[illegible] should be carefully supplied. Age [illegible] mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

(albert Guiman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63806

D 63806

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH In street in front of 1045 - Harford Ave

City of BALTIMORE: (No. 1045 - Harford Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME albert Guiman

(Residence in Baltimore: No. 1804 - Hope St St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. August (Month) 17th (Day) 1917 (Year)

7-AGE. 4 yrs. 8 mos. 14 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of Industry, business, or establishment in which employed (or employer). 900

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. albert Guiman

11-BIRTHPLACE (OF FATHER, (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Claude Shoemaker

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. I Robinson

(Address) 1804 - Hope St

15-

Filed ..... 192.... ROBERT R. KRAUTER, Registrar.

APR 28 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 26 (Day) 22 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism by auto

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Knox Souther M. D. (Coroner.)

192.. (Address) ...

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. 4/28/22 19...

20-UNDERTAKER. George J. Ruth ADDRESS 1735 - Harford Ave.

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. In the case of DEATH from violence state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. This certificate is very important.

(See Statement over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63807 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63807

CERTIFICATE OF DEATH.

139

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. Lombard & Greene ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Joseph C. Cuffley

(a) RESIDENCE. NO. 314 S. Payson ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Cuffley

6 DATE OF BIRTH (month, day, and year) Nov. 22. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam fitter 059

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Chas B. Cuffley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER A. Eccles Bashell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant University Hospital Records (Address)

15 Filed APR 28 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1922, to April 26, 1922, that I last saw h/m alive on April 26, 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

Myocardial Insuf (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms.

(Signed) Alberto Reece, M. D.

4-26, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL London Park — DATE OF BURIAL Apr. 29. 1922

20 UNDERTAKER George C. Schwab — ADDRESS 201 Eutaw Ave

mation should be carefully supplied. ... may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

UNIVERSITY HOSPITAL

LOMBARD AND GREENE STREETS

BALTIMORE, MD.

My dear Mr Green,

I am sorry to find that the man whose proper name was James C. Coppley is the same one whose death certificate was sent in under the name of Joseph C Coppley — All of the Hospital records had it as it was, hence my mistake.

Very truly yours —

Thomas Reese M.D.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63808

CERTIFICATE OF DEATH.

90 D 63808

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2602 E.Fayette St. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie L.Webster

(a) RESIDENCE. No. 2602 E.Fayette St. ST., WARD.

(Usual place of abode) * (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced.
HUSBAND of
(or) WIFE of Gabriel S.Webster

6 DATE OF BIRTH (month, day, and year) Aug.18.1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S Deal's Island
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Daniel

11 BIRTHPLACE OF FATHER (city or town) Somerset Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C.Wilson

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co.
(State or country) Maryland

14 Informant Gabriel S.Webster
(Address) 2602 E.Fayette st.

15 Filed APR 28 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April.26.1922 19

17 I HEREBY CERTIFY, That I attended deceased from June.1, 1922, to April 26, 1922, that I last saw her alive on April 25, 1922, and that death occurred, on the date stated above, at 3;30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Passagno, M. D.

4.27, 1922 (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4-28-22 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

mation should be carefully supplied. Avoid abbreviations. Write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63809

CERTIFICATE OF DEATH.

60-D 63809

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eva Jacobson

(a) RESIDENCE. NO. 807 Penna. ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Jacobson

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore St

15 Filed . 19

ROBERT R. KRAUTER Registrar

APR 28 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/22 19

17 I HEREBY CERTIFY, That I attended deceased from 4/25/22 19 to 4/27/22 19

that I last saw h[illegible] alive on 4/27/22 19

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exophthalmic Goitre

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/27, 19 22 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/28 1922

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

mation should be carefully supplied, so that it may be properly classified. Entries must be made in plain terms, so that it may be understood. Do not use abbreviations or ditto marks. CAUSE OF DEATH in plain terms, so that it may be understood. Do not use abbreviations or ditto marks. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63810

CERTIFICATE OF DEATH.

3/ D 63810

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Rutland Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jennings

(a) RESIDENCE. NO. 923 E Rutland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	Colored	Maried

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 870

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Co. Va.

PARENTS

10 NAME OF FATHER James Bland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Gabrial Jennings
(Address) 920 Rutland Ave

15 Filed . 19 ROBERT R. KRAUTER, Registrar

APR 28 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1922 to 4/26, 1922

that I last saw h alive on 4/26, 1922

and that death occurred, on the date stated above, at 11:20 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis? Clinical

(Signed) M. D. Robinson M. D.

(Address) 1526 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Colored Notaway Co Va

DATE OF BURIAL: April 29 1922

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS: 1726 Ashland

mation should be carefully supplied. Name and address of informant must be given. Be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire answer to each question is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

001

HEALTH DEPARTMENT—CITY OF BALTIMORE

63811

CERTIFICATE OF DEATH.

74 D 63811

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 529 N. Dallas ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Harvey

(a) RESIDENCE. No. 529 N. Dallas ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Noble Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Joseph Harvey 529 N Dallas St

APR 28 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1922 to April 26 1922

that I last saw her alive on April, 1922,

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) High blood pressure (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M D Robinson, M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery — DATE OF BURIAL April 29 1922

20 UNDERTAKER Mrs Robert A Elliott — ADDRESS 1729 Ashland Ave

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mallonee. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63812

CERTIFICATE OF DEATH.

101-09 D 63812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 16 WARD)

2-FULL NAME Charles Raymond Mallonee

(a) RESIDENCE. No. 1219 Hollins st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER James Mallonee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Farmd Md.

12 MAIDEN NAME OF MOTHER Bertie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Univ Hosp Records (Address) Lombard & Green

15 Filed APR 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922, to April 25, 1922, that I last saw him alive on April 25, 1922, and that death occurred, on the date stated above, at 5:05 p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia -

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examinatio

(Signed) W B Jones, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 28 1922
20 UNDERTAKER	ADDRESS 2236
Wm J. Hartwell.	N. Baltimore St.

mation should be carefully supplied, so that it may be properly classified. Exact information is required in all cases. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required in all cases. TION is very important. See instructions on back of certificates.

Spec. 6-9-10 H. P. Co.—1000 Bks.

D 63813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63813

CERTIFICATE OF DEATH.

4 X 159-003

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Aby Allen

(a) RESIDENCE. No. Towson Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Apr. 18, 1922

7 AGE: Years — Months — Days 9 — If LESS than 1 day, 8 hrs. or 23 mins.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Mercy Hospital Balto. Md.

PARENTS

10 NAME OF FATHER: Herschell Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mercy Hospital Reard

15 Filed APR 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1922 to Apr. 28, 1922 that I last saw her alive on Apr. 28, 1922 and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Bile ducts ??

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemolytic Jaundice

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign & Symptoms

(Signed) John J. Erwin M. D.

19, (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Cemetery - Govans

DATE OF BURIAL: Apr. 28 1922

20 UNDERTAKER: Henry W. Means & Son

ADDRESS: 805 N. Calvert St.

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63814 D 63814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Veterans' Hospital #56 REGISTERED NO. .....

CITY OF BALTIMORE: (No. Fort McHenry Md. ST., (Co. WARD) 24 X 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie. Blakely

(a) RESIDENCE NO. US. Veterans' Hospital #56 ST., Fort McHenry Md. WARD 39
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal miner. 086

(b) General nature of industry, business, or establishment in which employed (or employer) ------

(c) Name of employer --------

9 BIRTHPLACE (city or town) (State or country) Ohio/ unknown.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrock Registrar
(Address) US.V. Hosp. #56 Ft McHenry Md.

15 Filed APR 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1922 to April 25, 1922.

that I last saw him alive on April 25, 1922,

and that death occurred, on the date stated above, at 3,55 p.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far. adv. and active.

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) --- ------ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Clinic report.

(Signed) M.H. Foster M. D.

4/25. 1922 (Address) M.H. Foster Surgeon PHS. US.V. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL April 28th 1922

20 UNDERTAKER Harry H. Wehrle ADDRESS 153 N. Lombard st

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63815

CERTIFICATE OF DEATH.

1001

101

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Imwold.

(a) RESIDENCE. NO. 3502 Powlaton Ave ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma L Imwold.

6 DATE OF BIRTH (month, day, and year) May 24, 1853.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John A Imwold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wadunda Bibelhaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Emma L. Imwold

(Address) 3502 Powhatan Ave.

15 Filed APR 28 1922 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to April 26, 1922, that I last saw him alive on April 26, 1922, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Alcoholic Hepatitis. OVER

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Toxemia. Cardiac Failure (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 3502 Powlaton Ave

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Mitchell, M. D.

Apr. 26 1922 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Apr. 28, 1922

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 N. Dallas St

mation should be entirely complete, so that it may be properly classified. Each CAUSE OF DEATH in plain terms, so that it may be properly classified. Each TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history
No cholelithiasis

D 63816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1928-003 D 63816

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Hugh A. Barnes jr.

(Residence in Baltimore: No. 1533 Cole St.; yrs., 15 mos. 11 ds. 2)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. May (Month) 25 (Day) 1907 (Year)

7-AGE. 15 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Hugh A Barnes

11-BIRTHPLACE OF FATHER, (State or Country). Balto city

12-MAIDEN NAME OF MOTHER. Mary A Donaldson

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh Barnes

(Address) 1533 Cole St

15- GG

Filed APR 28 1928 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 27 (Day) 1928 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

fracture of Skull

Cuts & Bruises

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) fatal loss

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D. (Coroner.)

4-28 1928 (Address) 720 Cathedral St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death .... yrs. .... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Payson & Ramsay St

Former or usual residence 1533 Cole St

19-PLACE OF BERIAL OR REMOVAL. Mt Olivet Cem. DATE OF BURIAL. May 1st a. 1928

20-UNDERTAKER. Chas. B. Cook ADDRESS 1003 W Balto St

N. B.—Every item must be answered in plain terms, so that it may be understood. State CAUSE OF DEATH in plain terms, so that it may be understood. This is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

87 D 63817

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Wallace

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed APR 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to April 26, 1922, that I last saw her alive on April 26, 1922, and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Purulent pericarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde McKelvy, M. D.

4/27/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross 206 — DATE OF BURIAL 4-29 1922

20 UNDERTAKER E & B Starke — ADDRESS 115 Elwood Av

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63818

CERTIFICATE OF DEATH.

78 D 63818

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kunkel

(a) RESIDENCE. NO. Mt. Hope Retreat - ST., 28th WARD. Balto. Md.

(Usual place of abode)

Length of residence in city or town where death occurred Probably 25 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? Don't yrs. Know mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Kunkel

6 DATE OF BIRTH (month, day, and year) About - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt	72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 01⁵

(b) General nature of industry, business, or establishment in which employed (or employer) House Building

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Not Known.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat.

15 FILED APR 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3rd 1920, to April 28th, 1922, that I last saw him alive on April 27th, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Epilepsy - (Eclampsia)

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Post Epilepsy

0000 (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

April 28 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery	Apr 28 22
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63819

CERTIFICATE OF DEATH.

D 63819

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 S. Belnord Ave. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justina Miller

(a) RESIDENCE. NO. 625 S. Belnord Ave. 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs 7 mos 15 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late George Miller

6 DATE OF BIRTH (month, day, and year) Sept 11 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Martin Haad.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Krug.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John G. Miller (Son)
(Address) 625 S. Belnord Ave

15 Filed APR 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1922 to April 26 1922

that I last saw her alive on April 26 1922,

and that death occurred, on the date stated above, at 7 30 p m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. D. Beer, M. D.

4/27/22 (Address) 408 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL May 1 1922

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

mation should be carefully supplied. Let that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Brewington)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63820

D 63820

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Brewington

(Residence in Baltimore: No. 1714 Lorman St. Single yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 1 (Day) 1910 (Year)

7-AGE, 11 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Dallo Md

PARENTS.

10-NAME OF FATHER, Preston Brewington

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Snook

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Preston Brewington

(Address) 1714 Lorman St.

15- Filed ....., 191.....

Registrar.

APR 28 1922 Burial Permit Clerk.

N. B.—Every Return of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 24 1922, to April 26 1922 that I saw h.r alive on April 26 1922 and that death occurred, on the date stated above, at 5.50 A m.

The CAUSE OF DEATH* was as follows:

Streptococcus Infection of Face

(Duration) .....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) General Septicemia

(Duration) .....yrs.....mos. 2 ds.

(Signed) Newton D. Carr M. D.

4/26, 1922 (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 2 ds. In the State 11 yrs. 9 mos. 26 ds.

Where was disease contracted, if not at place of death? St Louis

Former or usual residence 1714 Lorman St

19-PLACE OF BURIAL, OR REMOVAL Mt Auburn Cem DATE OF BURIAL, April 29, 1922

20-UNDERTAKER Samuel Hemsley ADDRESS 1528 Pine

Brewington & find that her death was due
to Natural Causes James W Fenton (Coroner)

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 63821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63821

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2639 Oak St ST.; VK WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Edward Mariner

(Residence in Baltimore: No. 2639 Oak Sts St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Oct (Month) 15 (Day), 1840. (Year)

7-AGE, 81 yrs. 6 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country) York Co. Pa.

PARENTS.

10-NAME OF FATHER, Jonathan Mariner

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Lydia Miller

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilbur Mariner

(Address) 2639 Oak St.

15- Robert F. Carrell

Filed ..... 191.... Burial Permit Clerk

Registrar.

APR 28 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 19 1922, to Apr 27 1922, that I saw h[illegible] alive on Apr 27 1922, and that death occurred, on the date stated above, at 7.10 p m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ....yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) ....yrs. mos. 1 ds.

(Signed) David H. Elcock M. D.

Apr 28, 1922 (Address) 1438 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hamplin

DATE OF BURIAL, April 29, 1922

20-UNDERTAKER Wm Cook

ADDRESS N Y & Mc

1 B.—Every item of information should be carefully obtained, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63822

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 904 N Caroline ST. 10 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Dorothy Knapp

(a) RESIDENCE NO. 904 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: wife of J J Knapp, living

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Henry Pike

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Dorothy Louise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Knapp

(Address): 904 N Caroline

15 Robert P. Harrison, Registrar

APR 28 1922 19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to Apr 26, 1922,

that I last saw her alive on Apr 25, 1922

and that death occurred, on the date stated above, at 7.40 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary): None Known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Edw. S Tonkin, M. D.

, 19 (Address) 3123 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 29 1922
20 UNDERTAKER	ADDRESS
Mrs Johannah Canoles	946 Aisquith st

N. B.—WRITE PLAINLY. AGE must be given. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63823

CERTIFICATE OF DEATH.

161-001

D 63823

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2430 Green Mount Av ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Rey

(a) RESIDENCE. No. 2430 Green Mount Av ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Harry P. Rey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Irene M Kelly

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Harry P Rey
(Address) 2430 Green Mount Av

15 Filed APR 28 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to April 27, 1922; that I last saw him alive on April 27, 1922; and that death occurred, on the date stated above, at 9-15 P. m.

The CAUSE OF DEATH* was as follows:

Premature, about 6½ or 7 mo
Debility
Foramen Ovale not closed

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Fair M. D.

, 19 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 28 1922

Commissioner Health.

JOHNS HOPKINS

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Dodrer) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63824

D 63824

CERTIFICATE OF DEATH.

X 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas B. Dodrer

(a) RESIDENCE NO. Westminster Mds ST., WARD Westminster Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred , yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/22/1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster (State or country) Md

PARENTS

10 NAME OF FATHER Murray Dodrer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Bunnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas. B. Dodrer (Address)

15 Robert F. Harrison, , 19 Registrar

R 2 8 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28 1922

17 I HEREBY CERTIFY, That I attended deceased from 4.4, 1922, to 4/28, 1922, that I last saw her alive on 4/28, 1922, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Pan jremes Hemorrhage

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

~~Cardiac insufficiency~~ (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Westminster Md

Did an operation precede death? yes Date of 4/14/22

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. D Douglass, M. D.

, 19 (Address) Mary and Penn Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bretharn Cemetery — DATE OF BURIAL April 30 1922

20 UNDERTAKER James H. Stones — ADDRESS Westminster

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63825

CERTIFICATE OF DEATH.

164

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH —

CITY OF BALTIMORE: (No. 1608 Laurel Ave ST.: 16 WARD)

2-FULL NAME Mary T. Taylor

(a) RESIDENCE. NO. 1608 Laurel Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo E Taylor

6 DATE OF BIRTH (month, day, and year) 1832 - Feb 3.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	90	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Larkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia A. Burgess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs O. A. Taylor (Address) 1608 Laurel

15 Filed 4/28 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch - 5 1922, to Apr 28, 1922, that I last saw h[er] alive on Apr 27, 1922, and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH was as follows:

Senility. General asthenia

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No. What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

4/28 1922 (Address) 2702 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL May 1 1922

20 UNDERTAKER Joseph Ahern — ADDRESS 231 E Broadway

N. B.—WHITE ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

R28 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63826

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital X 57

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green ST.: H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Norris

(a) RESIDENCE. NO. Sylesville Md ST. WARD. Sylesville Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mold	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant W. Abernathy
(Address) 1617 Huntingdon Ave

15 Filed APR 28 1922, 19 [illegible] Registrar

[illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-20, 1922, to 4-28, 1922, that I last saw h[illegible] M alive on 4-28, 1922, and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Carbuncle of stock of neck

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (Coma)

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-21-22

Was there an autopsy? no

What test confirmed diagnosis? clinical finding

(Signed) [illegible] M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Sylesville Md. DATE OF BURIAL 4/29 19[illegible]

20 UNDERTAKER Wm Cook ADDRESS 502 E Wath

R.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63827

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1150 W Hamburg ST.: 21 WARD)

2-FULL NAME Aubry B. Yealdhall

(a) RESIDENCE. NO. 1150 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Bettie R. Yealdhall

6 DATE OF BIRTH (month, day, and year) April 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45		7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Deler
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md

PARENTS

10 NAME OF FATHER Mary Emmett

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co Md

12 MAIDEN NAME OF MOTHER Bason Yealdhall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co Md

14 Informant Bettie R. Yealdhall
(Address) 1150 W Hamburg

Apr 28 1922 Robt P. Harrison, Registrar

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1919, to Apr 28, 1922, that I last saw h[er] alive on Apr. 15, 1922, and that death occurred, on the date stated above, at 1.15 4 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Deverell, M. D.

Apr 28 1922 (Address) 621 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover A.A.Co — DATE OF BURIAL 4/30 22

20 UNDERTAKER Williams Cook — ADDRESS 502 E Wath

mation should be carefully applied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

OR 28 1922

D 63828

D 63828

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 E. Madison ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Kleinfelter

(a) RESIDENCE. No. 602 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Christian Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Carrie A. Brown 602 E. Madison

15 [illegible] 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 — 27 — 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1922, to Apr 26, 1922, that I last saw her alive on Apr 26, 1922, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

4/28, 1922 (Address) 733 Aisquith st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity	4/29 192
20 UNDERTAKER Cook	ADDRESS

mation should be carefully prepared, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 63829 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63829

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Mercy Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincenzo Raimondo

(Residence in Baltimore: No. 2235 Huntingdon St., 8 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH, unknown (Month) ..... (Day) ....., 1..... (Year)

7-AGE, 16 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 173
(b) General nature of industry, business, or establishment in which employed (or employer) P.R.R.Co

9-BIRTHPLACE, (State or Country) Italy

PARENTS.

10-NAME OF FATHER, R.V. Raimondo

11-BIRTHPLACE OF FATHER, (State or Country) Italy

12-MAIDEN NAME OF MOTHER, Rosaria Lerosa

13-BIRTHPLACE OF MOTHER, (State or Country) Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Guiseppe Raimondo

(Address) 2235 Huntingdon

15- Robert J. Griffith, Deputy Health Commissioner

Filed ..... 192..... Registrar.

APR 28 1922 Deputy Health Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 26 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull (Accidental) Injury

Below knee by Pass. R.R. Engine or Train

Duration: ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) From burns

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Tuley M. D.
(Coroner.)

Apr. 28 1922 (Address) 1639 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincents — DATE OF BURIAL, 4/29 1922

20-UNDERTAKER, William Cook — ADDRESS 502 E North

N.B.—Every item of information called for must be properly answered. To state CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63830

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 24 WARD)

2-FULL NAME Elizabeth Gayo

(a) RESIDENCE No. 1370 Andrea ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 25, 1854

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Max Kern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Lindauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo. Gayo, Jr.

(Address) 370 Fenwick St

15 Filed , 19 Registrar

R 2 8 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr-5, 1922, to Apr-27, 1922, that I last saw her alive on Apr 27, 1922 and that death occurred, on the date stated above, at 9.25 A m.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis Of

Chronic Interstitial Nephritis

Gangrene of left foot & lower leg.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/6-22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Newton J. Parr, M. D.

4-1, 1924 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: April 24 1922

20 UNDERTAKER: Margaret E. Flynn

ADDRESS 1422 Light St

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gangrene due to sclerosis. Operation for gangrene

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63831

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1023 Broadway ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Feehley

(a) RESIDENCE. NO. 1023 Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 3 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Martin H Feehley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Barbara Hergenhahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Martin H. Feehley

(Address) 1023 Broadway St.

15 Filed APR 28 1922 Registrar

Assistant City Health Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to April 27, 1922

that I last saw him alive on April 26, 1922,

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pott's

Tuberculosis Cervical

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gundrum, M. D.

4/28, 1922 (Address) 517 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem DATE OF BURIAL: April 29 1922

20 UNDERTAKER: Maynard S. Flynn ADDRESS: 1422 Eutaw St

mation should be written in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history

Hematuria.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63832

D 63832

CERTIFICATE OF DEATH.

REGISTERED NO. X 84

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. " " ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Winona V. Alexander

(a) RESIDENCE NO. Madera Clearfield Co ST., WARD Madera Penna,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) June 13-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Madera Clearfield Co Penna

PARENTS

10 NAME OF FATHER Joseph Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Susanna Hegerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed . 19 Registrar Robert P. Harrison, Burial Permit Clerk.

APR 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 19

17 I HEREBY CERTIFY, That I attended deceased from April 26- , 1922, to April 28- , 1922, that I last saw her alive on April 28- , 1922, and that death occurred, on the date stated above, at 10.15 P- m.

The CAUSE OF DEATH* was as follows:

Hypophyseal Tumor

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Operative shock 8 hrs

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Apr 28, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Operation, Autopsy

(Signed) W. M. Zinninger, M. D.

Apr , 1922 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Madera Pa

DATE OF BURIAL Apl 29 1922

20 UNDERTAKER Joseph Ahern

ADDRESS 226 Bway

N. B. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63833

CERTIFICATE OF DEATH.

D 63833

REGISTERED NO. 001 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 720 S Bond ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mebea

(a) RESIDENCE. NO. 720 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Mebea

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

11 Informant Annie Mebea (Address) 1709 Aisquith St

15 Filed Robert P. Harrison, Registrar

R 2 9 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24 1922, to July 27 1922, that I last saw h. alive on July 27 1922, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Stephenson M. D.

(Address) 1028 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 29 1922

20 UNDERTAKER Geo. E. Crockett — ADDRESS 1906 E. Pratt

mation should be carefully supplied, so that it may be proper... CAUSE OF DEATH in plain terms, so that it may be proper... TION is very important. See instructions on back of certific...

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63834

CERTIFICATE OF DEATH.

1001

161 D 63834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2547 Fleet ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina Josephine Miceli

(a) RESIDENCE NO. 2547 Fleet ST., 1 WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Sam Miceli

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Carmela Fortunato

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Sam Miceli
(Address) 2547 Fleet St.

15 Filed ....., 19..... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to April 28, 1922, that I last saw her alive on April 27, 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(Seven months' miscarriage) (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Guarino, M. D.

4.28.22. 19 (Address) 2911 Hills.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL April 29 1922

20 UNDERTAKER Lilly & Geiler — ADDRESS 403 S. Mo[illegible]

mation should be entirely supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

B2 01922

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63835

D 63835

CERTIFICATE OF DEATH.

178

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Bank St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Baldwin.

(a) RESIDENCE. NO. 1609 Bank St. 3 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of the late Elizabeth Baldwin

6 DATE OF BIRTH (month, day, and year) aug 15th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Balto City

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman - 032

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant (Address) Henry J. Baldwin 1609 Bank St (Son)

15 Filed ..... 19 ..... Registrar

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16th, 1922, to April 26th, 1922, that I last saw him alive on April 26th 1922, and that death occurred, on the date stated above, at 6 50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

ovd

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Uremia. Albumen

(Signed) J. W. Wade, M. D.

, 19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL April 29th 1922

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63836

34

D 63836

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McLain

(a) RESIDENCE. NO. University Hospital ST., 201 Rockdale Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas F McLain Sr.

6 DATE OF BIRTH (month, day and year) [illegible] 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) 107

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Levi McKinsey

11 BIRTHPLACE OF FATHER (city or town) [illegible] (State or country) Hagerstown Md.

12 MAIDEN NAME OF MOTHER McCormick

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown (State or country) Md.

14 Informant John F McLain Sr. (Address) 201 Rockdale Ave

15 Filed PR 2 9 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 1921 to April 27 1922, that I last saw h[illegible] alive on April 27 1922, and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Dorsal Pott's

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) K. B. Jones, M. D.

4/27. 1922 Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	4-29 1922
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Hollins st

mation should be carefully supplied. Any [illegible] may be properly classified. Exact statement of [illegible] CAUSE OF DEATH in plain terms, so that it may be [illegible] TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63837

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1317 Edmondson Ave. WARD 19)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Fay Davis

(a) RESIDENCE. No. 1317 Edmondson Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): April 21 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.
			6d	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Harry J. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary E. Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Harry J. Davis

(Address): 1312 Edmondson Ave.

15 Filed APR 29 1922 Robert P. [illegible], Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1922

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1922, to April 27, 1922, that I last saw him alive on April 27, 1922, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Congenital Atalectasis
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): High Forceps Operation
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Machen, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	April 29 1922
20 UNDERTAKER: Daniel Easton	ADDRESS 916 Pa Ave

mation should be carefully written in ink. CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63838

D 63838

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1841 N. Rutland ave ST., 8 WARD)

2-FULL NAME Alberta Durkee

(a) RESIDENCE NO. 1841 N. Rutland ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Henry B. Durkee

6 DATE OF BIRTH (month, day, and year) May 24th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis A Desvernoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Calvert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Frank H Durkee 2032 E 32nd st

15 Robert F. Harrison, Registrar

R 2 91922 .19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 15 .1922. to Apr 27 .1922.

that I last saw h W alive on Apr 27 .1922.,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) 2 yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob Fisher, M. D.

4/28 1922 (Address) 1823 N. Wash st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL May 1st 1922

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument st

B.—WRITE ... should be carefully supplied. ... may be properly classified. ... mation should be carefully supplied. ... may be properly classified. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63839

CERTIFICATE OF DEATH.

101

0 D 63839

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15-5- W. Henrietta ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm B. Howe

(Residence in Baltimore: No. 15-5- W. Henrietta St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	col.	married

6-DATE OF BIRTH, Feb. (Month) 26 (Day), 1879 (Year)

7-AGE.	If LESS than 1 day, ...hrs. or.....min.?
42 yrs. ..... mos. ..... ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stone cleaner
(b) General nature of industry, business, or establishment in which employed (or employer)..... City

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Boots.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Martha Howe.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie V. Brown

(Address) Calvert co. Md.

15-

Filed ....., 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

PR 2 9 1922

CAUSE OF DEATH in plain terms, so that it can be understood. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 24 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1922, to April 24 1922, that I saw h[im] alive on April 23 1922, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

2 hrs Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Shemwell M. D.

April 26, 1922 (Address) 2226 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Island Creek Calvert Co. Md. DATE OF BURIAL. April 30 1922

20-UNDERTAKER J. F. Brown & Son ADDRESS Va. & Monroe St

Route. M D V. R.R. to Parkers Wharf Calvert co. Md

D 63840

HEALTH DEPARTMENT—CITY OF BALTIMORE (Perak) ✓ D 63840

CERTIFICATE OF DEATH.

1922 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 18 Ward)

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Michael Perak

(Residence in Baltimore: No. 1240 W Pratt St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	—

6-DATE OF BIRTH, April (Month) 23 (Day) 1862 (Year)

7-AGE, 60 yrs. mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(h) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Austria

PARENTS.

10-NAME OF FATHER, John Perak

11-BIRTHPLACE OF FATHER, (State or Country): Austria

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country): Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Castele

(Address) 405 S Norris St

15- Robert V Harrison, Registrar.

Filed 4 29 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 27 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Compression Meningitis Compound Fracture, Left Orbital & Temporal Bones Homicide (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) James H. Fenton M. D. (Coroner)

4 29 1922 (Address) 7 W Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1240 W Pratt St

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, April 29 1922

20-UNDERTAKER, John J Fields — ADDRESS 1200 W Fayette

NOTE.—Every item of DEATH in plain terms, so that it may be properly state CAUSE of DEATH. See instructions on back of certificate. is very important.

Hit by other man. Don't know whether
first of what deceased was hit with.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

D 63841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63841

CERTIFICATE OF DEATH.

100-007

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3425 Druid av St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Detter

(Residence in Baltimore: No. 3425 Druid av St.; yrs. 3 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Dec 23 1918
(Month) (Day) (Year)

7-AGE. 3 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work.....000
(b) General natnre of industry, business, or establishment in which employed (or employer) Dependent

9-BIRTHPLACE. (State or Country) Baltimore md

PARENTS.

10-NAME OF FATHER, John Detter

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Kate Stamm

13-BIRTHPLACE OF MOTHER, (State or Country) Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Detter

(Address) 3425 Druid av

15- Robert P. Harrison, Registrar.

Filed APR 26 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 26, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....hrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward J. Gill M. D.
(Coroner.)

April 27 192 2 (Address) 1500 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery. DATE OF BURIAL, May 1 1922

20-UNDERTAKER, H. Sanders Sons ADDRESS 1710 Pent St

Every death must be reported to the Health Department within 24 hours. State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. This certificate is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63842

D 63842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. " " " ST., 16 WARD)

2-FULL NAME James Tilghman

(a) RESIDENCE NO. 120 N. Amity St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Susie Tilghman

6 DATE OF BIRTH (month, day, and year) July - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Tilghman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Hagerstown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 JOHNS HOPKINS HOSPITAL

Informant

(Address)

15 Filed Apr 29 1922 Robert P. Bartlett, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1922, to April 27 1922

that I last saw him alive on April 27, 1922

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

Symptoms

Uraemia (duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy Blood Chemistry

(Signed) Francis R. Dieuaide, M. D.

Apr 28, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Apr 30 22
20 UNDERTAKER James H. Deans	ADDRESS 205 Gay East

R 29 1922

B. [illegible] should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

(Ducket)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63843

CERTIFICATE OF DEATH.

162 D 63843 Registered No. C.....

D 63843
1-PLACE OF DEATH
City of BALTIMORE: (No. 525 Aliceanna St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Ducket
(Residence in Baltimore: No. 525 Aliceanna St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, ~~Married~~, Widowed, ~~or Divorced~~ (Write the word.)
Female	White	Single

6-DATE OF BIRTH April 27 1922
(Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... —
(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

9-BIRTHPLACE. (State or Country). Md

PARENTS

10-NAME OF FATHER. Fredrick Ducket

11-BIRTHPLACE OF FATHER. (State or Country). Poland.

12-MAIDEN NAME OF MOTHER. Margaret Simich

13-BIRTHPLACE OF MOTHER. (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fredrick Ducket
(Address) 525 S. Port st.

15-
Filed APR 29 1922 G. G. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 26 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Asphyxia Neonatorum
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Premature Confinement
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. Leslie Perry M. D.
(Coroner.)
192 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St Patricks ~~New Cathedral Cemetery~~ DATE OF BURIAL. April 29 1922

20-UNDERTAKER. Geo. J. Ruth ADDRESS 735 Hanford ave.

state CAUSE OF DEATH in plain terms, so that no other certificate is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63844

D 63844

CERTIFICATE OF DEATH.

4/29

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 E. Randall ST.: 24 WARD)

2-FULL NAME Hazel Marie Tracy

(a) RESIDENCE. NO. 503 E. Randall ST., 04 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery

(c) Name of employer Md. Biscuit Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. E. Tracy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Edna A. Ulrich 227 N. Rose St.

15 Filed APR 29 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.27 1922

17 I HEREBY CERTIFY, That I attended deceased from 4.15.22, 19..., to 4.26, 1922, that I last saw her alive on 4.26, 1922, and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical - Urine -

(Signed) Philip S. Fowler, M. D.

4.27, 1922 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	4/29 1922
20 UNDERTAKER John J. Gahegan & Sons	ADDRESS 1316 Eutaw St

mation should be entered, if known, so that it may be properly classified. Items must be entered in plain terms, so that it may CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Date of burial extended May 1/22 J.A.H. Hunt & Temple Asst Com.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63845

CERTIFICATE OF DEATH.

D 63845 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp't ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. James F. Donahue

(Residence in Baltimore: No. 317 S. Broadway St.; 64 yrs., 2 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb. 1st (Month) (Day), 1858 (Year)

7-AGE, 64 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer): 018

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Thomas Donahue

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Carey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss anna Cunningham

(Address) 425 E. 25th St.

15- Filed APR 29 1922, 191... J. C. Wilson Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 26th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 21 1922, to April 26 1922, that I saw him alive on April 26 1922, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning,
Nephritis, Chronic,
(Primary) Pneumonia
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) S. Lloyd Johnson M. D.
191... (Address) Bon Secours Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 5 ds. In the State 64 yrs. 2 mos. 25 ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence (317 S. Broadway)

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, 5-1-, 1922

20-UNDERTAKER J. A. Moran ADDRESS 3000 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63846

CERTIFICATE OF DEATH.

D 63846

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 N. Calhoun ST., 19 WARD)

2-FULL NAME Edwin T. Ward

(a) RESIDENCE NO. 526 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace A. Ward

6 DATE OF BIRTH (month, day, and year): 1843

7 AGE: Years 79 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Peter C. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Ann Forbes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass.

14 Informant: Grace A. Ward (Address) 526 N. Calhoun St.

15 Filed 19 Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to April 27, 1922, that I last saw h[illegible] alive on April 27, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Dilitation of heart.

(duration) 10 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis (duration) One yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) M. Byers M. D.

4/28 1922 (Address) 1405 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: May 1 1922.

20 UNDERTAKER: M. Lahey & Son. ADDRESS: 824-40 North ave.

APR 25 1922

Mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63847

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 121 W. Saratoga ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Cole.

(a) RESIDENCE NO. 121 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	~~5 Single~~, Married, ~~Widowed, or Divorced, (write the word)~~
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Cole

6 DATE OF BIRTH (month, day, and year) February 8th, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co MD.

PARENTS

10 NAME OF FATHER Aquilla McComas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Maryland

12 MAIDEN NAME OF MOTHER Elizabeth A. Slade.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Maryland

14 Informant William A. Cole

(Address) 2880 Woodbrook Ave

15 Filed ... 19 ... Registrar

4 29 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922, to April 28, 1922, that I last saw h[illegible] alive on April 28, 1922, and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency,

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) 1026 E. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 1st, 1922

ADDRESS 1123 N. Gay St

20 UNDERTAKER Putnam & Gore

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63848

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST.: 26 WARD)

2-FULL NAME John Joyce

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Joyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed 4 29 1922, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1922, to April 27, 1922

that I last saw him alive on April 27, 1922

and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Multiple abscesses L left leg - (Colon infection)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Sepsis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 4-19-22

Was there an autopsy? no

What lest confirmed diagnosis? Clinical findings

(Signed) Lt. Brumbach, M. D.

4/28/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

APR 29 1922

UNIVERSITY OF MARYLAND

Reg. No. [illegible]

Name of child must be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63849

D 63849

CERTIFICATE OF DEATH.

100-00!

1-PLACE OF DEATH U.S. Veterans' Hospital #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Washington

(a) RESIDENCE NO. 30 N. Caroline St., Baltimore, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52		-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E. T. Rosenbrock

(Address) Registrar

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/22 19

17 I HEREBY CERTIFY, That I attended deceased from 10/12/ , 19 21 , to 4/27/ , 19 22 ,

that I last saw him alive on 4/27/22 , 19 ,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Goitre, toxic

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dilatation cardiac acute Broncho- neumonia

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4/26/22

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. A. Foster Surgeon U.S.N. , M. D.

, 19 (Address) Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem.

DATE OF BURIAL April 27 1922

20 UNDERTAKER H. K. Wittsee

ADDRESS 1531 W. Lombard St

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

R2 1922

Spec.—6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63850

CERTIFICATE OF DEATH.

D 63850

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 Braddish ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Lauber.

(a) RESIDENCE. No. 1733 Braddish ave ST.. WARD. Reisterstown Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs 5 mos ds. How long in U. S., if of foreign birth? Reisterstown Md.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Anna Lauber.

6 DATE OF BIRTH (month, day, and year) Oct 27. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tobacconist

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany 58 yrs.

PARENTS

10 NAME OF FATHER John Lauber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lauber (Address) 1733 Braddish ave

15 Filed , 19 Registrar

1922 Burial Permit Clerk

N. B.—WHITE PAPER must be used. All items must be carefully supplied. Age must be stated in years, months and days. Information should be carefully supplied. Age must be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922 to April 28, 1922 that I last saw h. alive on April 27, 1922 and that death occurred, on the date stated above, at 1.30a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy. (See back)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? Usual

(Signed) George C. Shannon, M. D.

4/5 1922 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 1 1922
20 UNDERTAKER	ADDRESS
W. M. Rountree	2238 N Monastery

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

I saw patient first Apr. 27/22 when he was conscious and suffering from nausea and difficulty in breathing. 2 hrs later I was called and found patient unconscious with apoplectic attack from which he did not recover. Had known and attended patient at intervals during past 5 or 6 years

George C. Shannon

Spec.—1-10-21—M&T—1500 Bks.

D 63851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63851

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 808 N. Montford Ave. (WARD) 7

2-FULL NAME Josephine Stepanek

(a) RESIDENCE NO. 808 N. Montford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 38 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John Stepanek

6 DATE OF BIRTH (month, day, and year) June 6th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Bohemia (State or country) Europe

PARENTS

10 NAME OF FATHER Joseph Sticka

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country) Europe

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country) Europe

14 Informant Rose Stepanek (Address) 808 N. Montford Ave

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1922 to April 28, 1922 that I last saw h[illegible] alive on April 28, 1922 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 2 mo

CONTRIBUTORY (Secondary) Cardiac Paralysis (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. H. Rosenau, M. D.

(Address) 806 N. Montford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL May 1 1922

20 UNDERTAKER Zerkelen & Zerkelen — ADDRESS 1739 Eager

N. B. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

322

Spec.—1-10-21—M&T—1500 Bks.

D 63852

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63852

CERTIFICATE OF DEATH. 117

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 23 WARD)

2-FULL NAME Charles Taylor.

(a) RESIDENCE NO. Hanover St. Bridge ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Roberta Taylor

6 DATE OF BIRTH (month, day, and year) March 23, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	1	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles Taylor.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie Shields

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mrs. Carrie Brunning
(Address) Hanover St. Bridge

15 Robert P. Harrison, Registrar
APR 29 1922 , 19
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27. 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922, to April 27, 1922, that I last saw him alive on April 27, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendicitis
and Peritonitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction.
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Hanover St Bridge

Did an operation precede death? Yes Date of April 17, 19..

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John O'Hara, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 5/1/1922

ADDRESS

20 UNDERTAKER E. J. Fanning & Son 1460 Battery Ave

8.—Write plainly. Information should be carefully supplied. Items should be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

D 63853

HEALTH DEPARTMENT--CITY OF BALTIMORE

99-002

D 63853

CERTIFICATE OF DEATH

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 824 Edmondson Ave WARD) 17

2 FULL NAME Catherine G. Wilson

(Residence in Baltimore: No. 824 Edmondson Ave St.; 65 yrs. 3 mos. 16 ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 12 (Month) (Day), 1857 (Year) Abt.

7 AGE 65 yrs. 3 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Baltr. Md.

PARENTS

10 NAME OF FATHER Matthew Wilson

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rebecca Morehead

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva Wilson

(Address) 824 Edmondson Ave

15. Robert P. Harrison, ..., 191.....

Burial Permit Clerk. REGISTRAR

R 2 9 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. (Month) 28 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1921 to Apr. 27 1922

that I saw her alive on Apr. 27 1922

and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
Dilated Heart
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. R. Rider M. D.

Apr. 28, 1922 (Address) 867 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL May 1 1922

20 UNDERTAKER Robert S. Little ADDRESS 2706 Edmondson Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PRECISE OCCUPATION should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63854

D 63854

CERTIFICATE OF DEATH.

129

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Druid Hill Ave. St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie M. Tucker

(Residence in Baltimore: No. 1207 Druid Hill Ave.; 48 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) 15 (Day), 1874 (Year)

7-AGE, 48 yrs. ..... mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 037
(b) General nature of industry, business, or establishment in which employed (or employer)..... Housewife

9-BIRTHPLACE, (State or Country), Ind

PARENTS.

10-NAME OF FATHER, Wm H. Carroll

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Louisa Jayson

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther K. Tucker

(Address) 1207 Druid Hill Ave

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

R 2 9 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 12 1922, to Apr. 27 1922, that I saw h[illegible] alive on Apr. 27 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pyaemia

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) W. J. Carroll M. D.

Apr. 28, 1922 (Address) 5 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Loudon Tucker Cem[illegible]

DATE OF BURIAL, 5-1, 1922

20-UNDERTAKER George H. Holland

ADDRESS 1312 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63855

D 63855

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

63855

D 63855

179

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Mecker - Sr.

(a) RESIDENCE. No. 705 Boenecke Ave, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Marker

6 DATE OF BIRTH (month, day, and year) Oct 13 / 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5 5	6.	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Sarah Slater

(Address) 705 Boenecke Ave

15 Filed APR 3 1922 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to April 28, 1922, that I last saw him alive on April 28, 1922, and that death occurred, on the date stated above, at 8 Hrs 4 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 24 hours

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) H. B. Jones - M. D.

April 26, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hyattsville	May 1 1922

20 UNDERTAKER Walter Davis

ADDRESS 337 Kaye St

mation should be given in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Bks.

63856 D 63856

HEALTH DEPARTMENT—CITY OF BALTIMORE

63856 X31 D 63856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Veterans' Hospital #56

CITY OF BALTIMORE: (No. Fort Mc Henry Md. ST. 38 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolph Searles.

(a) RESIDENCE NO. US. Veterans' Hospital #56 ST., 38 WARD Fort McHenry Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Dolph Searles.

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work farmer. 086

(b) General nature of industry, business, or establishment in which employed (or employer) ------

(c) Name of employer -------

9 BIRTHPLACE (city or town) (State or country) West Virginia.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrock(Registrar)
(Address) US. V. Hosp. #56 Ft. McHenry Md.

15 F APR 30 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1922, to April 29, 1922, that I last saw h... alive on April 29, 1922, and that death occurred, on the date stated above, at 12'10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. & active.

(

------- (duration) -- yrs. -- mos ... ds.

CONTRIBUTORY (Secondary) ------

(duration) -- yrs. -- mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of ---

Was there an autopsy? No/

What test confirmed diagnosis? Clinical report.

(Signed) M. A. Foster, M. D.
Surgeon US. P.H.S.
4/29/22 (Address) US. V. Hosp. #56 Ft. McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Red House W. Va. | DATE OF BURIAL Apr 29 1922

20 UNDERTAKER Harry H. Witzke | ADDRESS 524 W Lombard St

N. B.—Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 63857

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 63857

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 570 Walnut alley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Cole

(Residence in Baltimore: No. 570 Walnut alley St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, about (Month) (Day), 1862 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 140
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER. (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916, Penna Ave,

15-

Filed APR 3 01922, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquis (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyaemia Heart disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. Hennessy M. D.
(Coroner.)

August 29, 1922 (Address) 28 E Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 8/30/22

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penn.

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 63858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63858

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope-Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Boland - (Boland)

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anton Boland

11 BIRTHPLACE OF FATHER (city or town) Braslar (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Issar

13 BIRTHPLACE OF MOTHER (city or town) Budapest (State or country) Austria -

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Balto Md

15 FILED APR 3 0 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1919, to April 28th, 1922, that I last saw h.Er alive on April 28th, 1922, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

abt (duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Manic Depressive

abt (duration) 7 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

April 28, 1922 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 1 1922

20 UNDERTAKER Chas E Cracken ADDRESS 1910 Orleans

mation should be carefully compiled, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. (See Nos. 16 and 17 and back of certificates.
TION is very important. See instructions on back

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63859

CERTIFICATE OF DEATH.

REGISTERED No. C 90 D 63859

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1623 Westwood Ave ST. 15 WARD)

2-FULL NAME Joseph R. O'Brien

(Residence in Baltimore: No. 1623 Westwood Ave.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

70 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, about (Month) (Day), 1852 (Year)

7-AGE, 70 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John O'Brien

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unk.

13-BIRTHPLACE OF MOTHER (State or Country), Unk.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. J. Haupt

(Address) 1623 Westwood Ave

15-APR 3 01922 ROBERT R. KRAUTER,

Filed ..... 191 ..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dropsy Heart disease

(Duration) ....yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 29, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, May 1st 1922

20-UNDERTAKER G. F. Walker ADDRESS 723 W. Lafayette ave

N.B.—Every item of information should be carefully given, so that it may be properly classified. Blank answers are misleading. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63860

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 D 63860

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Market ST. 14 WARD)

2-FULL NAME Addie Pennington

(a) RESIDENCE. NO. 629 Market ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5- 01

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Md

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mack Pennington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jamie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minnie Pennington
(Address) 629 Market St

15 APR 3 01922 ROBERT R. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2- 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to April 26, 1922

that I last saw h.. alive on April 26 1922

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Tubercular Cystitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Thumb

(Signed) Edw. J. Mueller, M. D.

4/6 1922 (Address) 1320 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 30 1922
20 UNDERTAKER	ADDRESS
Wm H. Grace Son	1900 Market

mation should be entered in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Priscilla Sneed

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 63861

CERTIFICATE OF DEATH.

14 D 63861

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 739 N. Dallas St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Priscilla Sneed

(Residence in Baltimore: No. 739 N. Dallas St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fenal

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month), 1 (Day), (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Mitchell Chase

(Address) 1400 Mosher

15-

FILED APR 3 0 1922 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

4-29, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn

DATE OF BURIAL, April 29, 1922

20-UNDERTAKER P. Mitchell Chase & Son

ADDRESS 1400 Mosher

N.B.—Every item of information should be carefully supplied. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Patts

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D 63862

D 63862

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 S. Carolina ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Patts

(a) RESIDENCE NO. 228 S. Carolina ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 25 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meyer Patts

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE — Years: 62 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis (Address) 1439 E. Baltimore St.

15 Filed APR 3 01922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28 1922

17 I HEREBY CERTIFY, That I attended deceased from June ..., 19.. to April 28, 19..,

that I last saw her alive on April 28, 19..,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical - Lab.

(Signed) D. E. Mackenzie, M. D.

, 19 (Address) 2-30 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrem Russdale — DATE OF BURIAL 4/30 1922

20 UNDERTAKER: Jack Lewis 1439 E. Balto St — ADDRESS .....

mation should be entered in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

90 D 63863

REGISTERED NO.

D 63863

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Fedder

(a) RESIDENCE. NO. 1111 Laurens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 4 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (illegible) 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hirshkovitz Fedder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rosa Feder

12 MAIDEN NAME OF MOTHER Rosa Feder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1429 E Balto St

15 Filed APR 3 01922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29/22 19

17 I HEREBY CERTIFY, That I attended deceased from 3/10/22, 19, to 4/29/22, 19, that I last saw h. alive on 4/29/22, 19, and that death occurred, on the date stated above, at 11.30 A, m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? *

(Signed) Zemberg M. D.

4/29, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal.. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	4/30 1922

20 UNDERTAKER ADDRESS

Jack Lewis 1429 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63864 ✓ D 63864

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1137 Popular Grove St. WARD 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Sullivan

(a) RESIDENCE. NO. 1132 Popular Grove St. WARD 1

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

Name John J. Sullivan

6 DATE OF BIRTH (month, day, and year) June 6 1856

7 AGE Years 65 Months 10 Days 24

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Dowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Mrs. E. Sullivan 1132 Popular Grove St.

15 APR 3 01922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 1921, to Apr. 29. 1922, that I last saw h alive on Apr. 29. 1922 and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. E. Brentnall, M. D.

4-30 19 22 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cath. Cedar

DATE OF BURIAL May 3 1922

20 UNDERTAKER Peter S. Lentz

ADDRESS 2700 Edmondson Av

matter should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

15-5-444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63865

1919 D 63865

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. " " ST., 4 WARD)

2-FULL NAME William Davis

(a) RESIDENCE NO. 756½ W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown do How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Sina Davis

6 DATE OF BIRTH (month, day, and year) July 23rd 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Isaac Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elnora Vaughn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed APR 3 01922 ROBERT M. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 22nd 1922 to April 28th 1922

that I last saw h~~im~~ alive on April 28th 1922

and that death occurred, on the date stated above, at 4:22 m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 756½ W. Saratoga

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Urine exam

(Signed) E. Cowles Andrus, M. D.

Apr. 28 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md.

DATE OF BURIAL: May 1 1922

20 UNDERTAKER: Hamme & Wright

ADDRESS: 124 McCulloh

mation should be carefully written in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.- 1-10-21- M&T - 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63866

REGISTERED NO. 90 D 63866

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4823 Park Hughton St., 24th WARD)

2-FULL NAME Margaret A. Koch.

(a) RESIDENCE NO. 4823 Park Hughton St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17. 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	86.	8	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Andrew Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles S Cobb

(Address) 2510 Pennsylvania Ave

15 ROBERT H. KRAUTER, Clerk.

File APR 3 01922 Burial Permit

N. B. ... mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of ... k of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1922

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1922, to April 28, 1922, that I last saw h alive on April 27, 1922, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

Mitral stenosis

(duration) yrs. 3 mos 25 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination

(Signed) H. M. Clemmer M. D.

4/29, 1922 (Address) 2703 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 1 1922

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

155397. D 63867. HEALTH DEPARTMENT—CITY OF BALTIMORE D 63867

CERTIFICATE OF DEATH. X 131

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 12 WARD)

2-FULL NAME Marion Hyser.

(a) RESIDENCE NO. Emmetsburg, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ ~~WIFE of~~: Stacia Hyser: (mother) 3982 Lobdell Ave.

6 DATE OF BIRTH (month, day, and year): Nov. 7, 1921.

7 AGE: Years — Months 5 — Days 22. — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Hyser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Stacia Barrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant (Address): Recorder JOHNS HOPKINS HOSP.

15 APR 3 01922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21. 1922. to April 29. 1922. that I last saw her alive on April 29. 1922 and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia, bronchopneu

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) T B Gay, M. D.

. 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Church Cem Emmitsburg DATE OF BURIAL: Apr 30, 1922

20 UNDERTAKER: William Cook ADDRESS: 502 E North Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63868

REGISTERED No. C 100 D 63868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Madison Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Spencer R Mullican

(Residence in Baltimore, No. 1409 Madison ave St. 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (~~Write the word.~~)

6-DATE OF BIRTH, April 11/22 (Month) 15 (Day) 04 (Year)

7-AGE, ... yrs. ..... mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓ 00
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Univ Md Hospital Balto Md

PARENTS.

10-NAME OF FATHER, Spencer R Mullican

11-BIRTHPLACE OF FATHER (State or Country), Montgomery Co Md

12-MAIDEN NAME OF MOTHER E Hill M. Soper

13-BIRTHPLACE OF MOTHER (State or Country), Montgomery Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Spencer R Mullican

(Address) 1409 Madison ave

15- Filed APR 3 01922, 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29 22 (Month) (Day) (Year) 1922

17- I HEREBY CERTIFY, That I attended deceased from Diagnosis Endocarditis 191.. to 191.., that I saw him alive on April 29th 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Contributory)

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) H A Hill M. D.

April 30, 191.. (Address) 1208 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oden Grove Montgomery Co Md — DATE OF BURIAL, Apr 30 1922

20-UNDERTAKER William Cook — ADDRESS 30 E North ave

N. B.—Every item of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63869

CERTIFICATE OF DEATH.

24-001

D 63869

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 346 S Calhune ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Horan

(Residence in Baltimore: No. 346 S Calhune St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	widow

6-DATE OF BIRTH, May (Month) 22 (Day) 1867 (Year)

7-AGE, 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Caslin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Zadan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Barber

(Address) 346 S. Calhune

15-

Filed APR 3 01922, 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1922, to April 28 1922, that I saw her alive on April 28 1922, and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward F. Travers M. D.

April 30 1922 (Address) 1520 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Joseph Texas — DATE OF BURIAL, May 1., 1922

20-UNDERTAKER John J. Fields — ADDRESS 1200 W Lombard

N.B.—Every item of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63870

CERTIFICATE OF DEATH.

D 63870

REGISTERED No. C 185

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt. Gen. Hosp. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Z. Taylor Darby

(Residence in Baltimore: No. 3819 Clifton Ave St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, Nov. 9, 1846
(Month) (Day) (Year)

7-AGE, 75 yrs. 5 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Tobacco

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Nicholas Darby

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ellen Burns

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Douglass Darby

(Address) 3817 Clifton Ave.

15-APR 3 01922 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary sclerosis and myocardial degeneration

(Duration) about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of femur.

(Duration) 1 yrs. 1 mos. 7 ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 29 1922 (Address) 3802 Edgewood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Lorraine Cemetery

DATE OF BURIAL, May 1, 1922

20-UNDERTAKER George J. Smith

ADDRESS 1000 N. Fayette Ave

N. B.—Every item of information should be carefully given, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Fracture caused by fall down steps

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63871

CERTIFICATE OF DEATH.

D 63871

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 N. Carey St. St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Edwin Smith.

(Residence in Baltimore: No. 220 N. Carey St. St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 24, 1867.
(Month) (Day) (Year)

7-AGE, 55 yrs. 1 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Notary Public
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Oliver Nicholas Smith

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Theresa Amelia Albright

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia M Smith

(Address) 220 N Carey St.

15- APR 30 1922 191... ROBERT R. KRAUTER, Clerk.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 26 1922, to April 27 1922, that I saw h-im alive on April 27 1922, and that death occurred, on the date stated above, at 10 26 P. m.

The CAUSE OF DEATH* was as follows:

Uremia.

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis (Duration) 3 yrs. ....mos. ....ds.

(Signed) Edgar E. Travers M. D.

April 28 1922 (Address) 1520 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, May 1 1922

20-UNDERTAKER George J. Smith

ADDRESS 1000 Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63872

74 D 63872 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1102 N. Fulton Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McIntyre

(a) RESIDENCE. NO. 1102 N. Fulton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H. C. McIntyre

6 DATE OF BIRTH (month, day, and year) May 14, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York, Pa

PARENTS

10 NAME OF FATHER James Templeton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Gipe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant George White (Address) 1102 N. Fulton Ave

15 Filed APR 3 0 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 '22

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15, 1922, to April 29, 1922, that I last saw h 12 alive on April 28, 1922, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis (Cerebral hemorrhage)

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Le Magness, M. D.

4-29, 1922 (Address) 1706 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Cem. York, Pa

DATE OF BURIAL: May 1 1922

20 UNDERTAKER: E. Le Roy Stiffler

ADDRESS: 125 E. North Ave

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63873

REGISTERED NO. 90 D 63873

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1106 N. Eutaw St ST.: [redacted] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mc. Gerry

(a) RESIDENCE. NO. 1106 N. Eutaw St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick McGarry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Hopkins

(Address) 426 N Charles

15 Filed APR 3 0 1922 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 20th, 1922, to April 27th, 1922, that I last saw her alive on April 27th, 1922, and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency,

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis, Senility. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) J. A. Shotard, M. D.

(Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 1 1922
20 UNDERTAKER	ADDRESS
Martin Bailey & Son.	1827 W Fayette

mation should be given in plain terms, so that it may be properly classified. Certificates of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63874

CERTIFICATE OF DEATH

100 001 D 63874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Berlin & Main Sts. 27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Marie Gerwig

(a) RESIDENCE. No. Berlin & Main Sts. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Jacob Gerwig

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Christina McCulloch

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Jacob Gerwig (Address) 1 Mt Meniah

15 Filed APR 3 01922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/20/22 19 , to 4/28/22 19 22 , that I last saw h alive on 4/28/22 19 , and that death occurred, on the date stated above, at 2 00 m.

The CAUSE OF DEATH* was as follows:

TOD

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen L. Dean M. D.

19 (Address) 1227 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn Park	May 1922

20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1324 W. PRATT STREET

ADDRESS

mation should be given in answering each question, so that it may be understood by those not familiar with technical terms. CAUSE OF DEATH in plain terms, so that it may be understood by those not familiar with technical terms. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63875

CERTIFICATE OF DEATH.

74-001

63875

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 N. Smith ST. Grayson WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie F. Bramble

(a) RESIDENCE. NO. 20 North 9th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Phillip Bramble

6 DATE OF BIRTH (month, day, and year): Apr 16 1861

7 AGE: Years 61 | Months — | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Maryland

PARENTS

10 NAME OF FATHER: John T. Bramble

11 BIRTHPLACE OF FATHER (city or town) (State or country): Stafford Co Maryland

12 MAIDEN NAME OF MOTHER: Ruth Swarting

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Stafford Co Maryland

14 Informant (Address): Mary A Asher 1750 E. Broadway Baltimore City Md

15 Filed APR 3 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 29 22

17 I HEREBY CERTIFY, That I attended deceased from April 19 1922 to April 29 1922 that I last saw h alive on April 29 1922 and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Paralysis

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary): Interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at her place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) George E. Boyle, M. D.

, 19 (Address) 10 N. Stafford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezer Cemetery Balto Co. md.	May 2 1922
20 UNDERTAKER	ADDRESS
H E Hughes	4 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

155313
D 63876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X49 D 63876

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

2-FULL NAME Rev. Albert A. Zabriskie

(a) RESIDENCE NO. 218 Hawthorne Ave. ST., ... WARD ..... City.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

over

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE~~ of Prof Robt. Hegner son-in-Law.

6 DATE OF BIRTH (month, day, and year) April 11, 1843.

7 AGE: Years 79 | Months — | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of Industry, business, or establishment in which employed (or employer) 018

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) New Jersey

PARENTS

10 NAME OF FATHER Albert M. Zabriskie

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) N. J.

12 MAIDEN NAME OF MOTHER Anne Tallmadge

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) N. J.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Baltimore

15 APR 3 01922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11 1922 to April 29 1922 that I last saw him alive on April 29 1922 and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia,

Uremia

(duration) 36 hours yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of prostate

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Rectal Examination

(Signed) Franklin P. Johnson, M. D.

1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manhassett, Long Island N.Y. DATE OF BURIAL May 1 1922

20 UNDERTAKER H. C. Hughes ADDRESS 41st & Broadway

mation should be entered, if known, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Came from New York
Here about 26 days.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63877

HEALTH DEPARTMENT—CITY OF BALTIMORE

146 D 63877

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE: (No. 3436 Belair Rd. ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Naoma Pettecord

(Residence in Baltimore: No. 3436 Belair Rd. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mch 19, 1900 (Month) (Day) (Year)

7-AGE, 22 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Rader

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Emma Baehgin

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest B. Pettecord

(Address) 3436 Belair Road

15- APR3 01922 Filed ..... 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 11 1922, to Apr 29 1922, that I saw h W alive on Apr 29 1922, and that death occurred, on the date stated above, at 12.20A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis C.C.

(Duration) .....yrs. .....mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Jacob Fassbon M. D.

4/29, 1922 (Address) 1823 N. Wash. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Parkwood

DATE OF BURIAL, May 1, 1922

20-UNDERTAKER Horace A. Burgee

ADDRESS 363 Falls Rd

CAUSE OF DEATH in plain terms. Omissions important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63878 ✓ D 63878

D 63878

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2837 Pennsylvania Ave ST.; 13 WARD)

2-FULL NAME John D. K. Bordner

(a) RESIDENCE NO. 2837 Pennsylvania Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Bordner

6 DATE OF BIRTH (month, day, and year) July 25th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Business

(b) General nature of industry, business, or establishment in which employed (or employer) J. K. Bailey Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co. Pa.

PARENTS

10 NAME OF FATHER John Bordner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elsie Bordner (Address) 2837 Pennsylvania Ave

15 Filed ..... 19 ..... Registrar

MAY 1 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30th 1922.

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 19xx to April 30 19xx

that I last saw h was alive on Apr 30 19xx

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. I.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Nathaniel Gorsh, M. D.

, 19 (Address) 2731 Parkwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shrewsbury York Co. Pa	May 2nd 1922
20 UNDERTAKER	ADDRESS
Wm. H. Teufel & Son	801 W. Fayette

INFORMATION MUST BE GIVEN IN PLAIN TERMS, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63879

CERTIFICATE OF DEATH.

D 63879

REGISTERED NO. 11-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Homestead ST., 9 WARD)

2-FULL NAME Norman J. Williams

(a) RESIDENCE NO. 930 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24. 20

7 AGE — Years: 2 | Months: 3 | Days: 4 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Aja Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Ruth E. Hoale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Aja Williams

(Address) 930 Homestead

15 MAY 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 5 1922, to Apr 29, 1922, that I last saw h[illegible] alive on Apr 29, 1922 and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B W Kelly M. D.

, 19 (Address) 100 N. Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 5 | 1 | 22

20 UNDERTAKER: William Cook

ADDRESS: 502 N Gay

mation should be clearly written, so that it may be properly entered.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

522 Jordan Dr/Bells.

D 63880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63880

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3947 Greenmount St. 91 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E. Shane

(Residence in Baltimore: No. 3947 Greenmount St.; yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, March 21, 1857 (Month) (Day) (Year)

7-AGE, 65 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, J. B. Kraemer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary J Berg

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur B. Justi

(Address) 616 N. Carrollton

15-

Filed MAY 1 - 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 27, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Knox Ingram M. D. (Coroner)

4-27, 1922. (Address) 4 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park | DATE OF BURIAL, May 1, 1922

20-UNDERTAKER Wm J Luckett & Son | ADDRESS N x Pa

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. Important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63881

CERTIFICATE OF DEATH.

90 D 63881

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 E. 30th ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina B. Sonneborn

(a) RESIDENCE NO. 1931 E. 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip H. Sonneborn

6 DATE OF BIRTH (month, day and year) Sept 8-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	7	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nassau Germany

PARENTS

10 NAME OF FATHER Carl Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Philip B. Sonneborn (Address) 1931 E. 30th St

15 Filed MAY 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1922, to apr. 26, 1922, that I last saw her alive on apr. 26, 1922, and that death occurred, on the date stated above, at 11 10 P. m.

The CAUSE OF DEATH* was as follows:

Decompensated Mitral Regurgitation

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1st ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos A. Stevens MD M. D.

4/27 1922 (Address) 2878 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 1922

20 UNDERTAKER Wm. J. Tuckwell & Son — ADDRESS W. Pa

mation should be carefully supplied, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63882

CERTIFICATE OF DEATH.

REGISTERED NO. 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 W. North Ave ST., 15 WARD)

2-FULL NAME Mary Julia Paulus

(a) RESIDENCE NO. 2901 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hea a. Paulus

6 DATE OF BIRTH (month, day, and year) Apr. 10 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John G. Steigel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Julia Irving

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Carroll M Paulus (Address) 290[illegible] North Ave

15 Filed MAY 1 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1921, to Apr 28, 1922, that I last saw h. alive on Apr 28, 1922, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) x yrs. 2 mos x ds.

CONTRIBUTORY (Secondary) Oral sepsis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jesse Talbot, M. D.

, 19 (Address) 135-3 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	May 1 1922
20 UNDERTAKER Wm J Jackson Sons	ADDRESS North Ave

N. B. ... mation should be carefully supplied ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr Talbot
1353 W. North ave
Result of bad teeth

Spec.—1-10-21—M&T—1500 Bks.

D 63883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 515 E 22nd ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Hitchcock.

(a) RESIDENCE No. 515 E 22nd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H Hitchcock

6 DATE OF BIRTH (month, day, and year): 1840

7 AGE: Years 81; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James A Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary E Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Henry C Hitchcock

(Address): 515 E 22nd St

15 Filed 5 6, 19 MAY 7 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28th 1922

17

I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1922, to Apr. 28, 1922,

that I last saw h alive on Apr. 28, 1922,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Fracture left Hip. "Neck of Femur." Impacted on

Corset (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

Pulmonary Oedema, (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes (over)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. T. Mears, M. D.

1927 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 11 1922

20 UNDERTAKER: Robt E Turner Inc — ADDRESS 1442 Broadway

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63884

CERTIFICATE OF DEATH.

D 63884

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1100 Whitmore Ave ST., 16 WARD)

2-FULL NAME John Francis Crapsey

(a) RESIDENCE NO. 1100 Whitmore Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1917

7 AGE — Years 5 | Months 3 | Days 1 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Francis Crapsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Edith Mae Eckles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) John F. Crapsey 1100 Whitmore Ave

15 Filed MAY 1-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 26, 1922, to Apr 29, 1922, that I last saw him alive on Apr 28, 1922, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis.
Mother reported child not been sick for a month.

CONTRIBUTORY (Secondary) Malnutrition (duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. Olive Murray, M. D.

Apr 29 1922 (Address) 1721 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 5/1 1922

20 UNDERTAKER William Cook — ADDRESS 502 E North

mation should be carefully answered, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63885

63885

CERTIFICATE OF DEATH.

REGISTERED NO. 58-006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Gen Hosp'l St. Wolfe WARD)

2-FULL NAME Frank Alexander Meikle

(a) RESIDENCE NO. 3115 Clifton Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widowed

6 DATE OF BIRTH (month, day, and year) Dec 15. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist 025

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Steubenville

(State or country) Ohio

PARENTS

10 NAME OF FATHER Alex. Meikle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Stirk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Alex. C. Meikle

(Address) 3115 Clifton Ave

15 Filed MAY 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922.

17 I HEREBY CERTIFY, That I attended deceased from 4/24/22 to 4/29/22, 19

that I last saw him alive on 4/28/22, 19

and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Cardiac Dil

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clynical findings

(Signed) J. A. Tompkins M. D.

, 19 (Address) Mt Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Druid Ridge DATE OF BURIAL May 2. 1922

20 UNDERTAKER John Oursler ADDRESS 1201 W. Fayette St.

Information should be carefully supplied. Avoid use of terms which may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 63886

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

123 D 63886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Jefferson ST.: 5 WARD)

2-FULL NAME Susie R. Bell

(a) RESIDENCE. No. 1421 Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Francis Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Ida Bailey (Friend)
(Address) 1421 Jefferson St

15 Filed ..., 19 MAY 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28 1922

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 28, 1922, that I last saw her alive on 4/27, 1922, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Gall stones

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical + Lab

(Signed) R. J. Young, M. D.

, 19 (Address) 1429 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shara St. Cemetary — DATE OF BURIAL: May 1922

20 UNDERTAKER: Chas. O. Bailey — ADDRESS: 1421 Jefferson

CAUSE OF DEATH in plain terms, so that it may be certificates. TION is very important. See instructions on back of certificates.

RZa

D 63887

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 63887

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2724 N. Charles (Homewood Hosp) ST. 7th WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Stumpf

(Residence in Baltimore: No. 2574 Hollins St ST.; 60 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: Mar 20th (Month) (Day), 1845 (Year)

7-AGE: 77 yrs. 1 mos. 9 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): =

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: J. Stumpf

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna C. Stumpf

(Address) 2574 Hollins St

15.

Filed ....., 191 MAY 1 — 1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 29 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to April 29 1922, that I saw him alive on April 28 1922, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Infected wound right ankle, cellulitis, Amputation of right leg below knee, (Senile Gangrene Post Operative) (Duration) 1 yrs. 3 mos. 24 ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Vernon H Condon M. D.

April 29, 1922 (Address) 750 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: May 2nd, 1922

20-UNDERTAKER: R B Wagner — ADDRESS: 2336 Eutaw Ave

N. B.-Every item of information should be carefully supplied. AGE should be filled out in full. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

63888

HEALTH DEPARTMENT—CITY OF BALTIMORE

63888

CERTIFICATE OF DEATH.

REGISTERED No. C 74-001

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Little Sisters of Poor. St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Gilmore

(Residence in Baltimore: No. Prentis & Vallee. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	widower

6-DATE OF BIRTH, ... (Month) ..... (Day), 1 (Year)

7-AGE, 84 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters

15- Filed MAY 1 - 1922, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 30 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Knox Snider M. D. (Coroner)

4-30, 1922 (Address) 4 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, May 1, 1922

20-UNDERTAKER J. C. Windfield — ADDRESS 914 Gramont Ave

N. B.—Every item of information should be carefully classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly coded, is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

155390. 63889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 63889

38

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. " " " ST., 9 WARD) City

2-FULL NAME Harid Redd.

(a) RESIDENCE NO. 1744 Ashland Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a (If married, widowed, or divorced) ~~HUSBAND of~~ ~~(or) WIFE of~~ Estelle Hunter Redd Half brother

Address, U. S. Navy Yard, Mare Island

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 Filed MAY 1 1922 Registrar

107 a

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1922 to April 21 1922

that I last saw him alive on April 21 1922

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

1 hour (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxic Insufficiency

Syphilis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Francis R. Dieuaide M. D.

Apr 28, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: May 1 1922

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1225 Ashland Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

63890

HEALTH DEPARTMENT—CITY OF BALTIMORE

63890

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 907 McDonough ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina Faulkner

(a) RESIDENCE. NO. 907 McDonough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of I Don't Know

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Littleton N.C.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER I Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) I do not know

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Claude Williams

(Address) 907 McDonough St

15 Filed MAY 1 1922 Registrar

M.F.W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 28 Ap. 1922

17 I HEREBY CERTIFY, That I attended deceased from 10 Ap., 1922 to 28 Ap., 1922.

that I last saw h[illegible] alive on 28 Ap., 1922.

and that death occurred, on the date stated above, at 10.10 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza (duration) 1 yrs. mos.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emmett Field Boyd, M. D.

29 (Address) 1615 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littleton N. Carolina

DATE OF BURIAL May 1 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

N. B.—[illegible] should be carefully supplied. All should be properly classified. Exact statement of occupation should be given in plain terms, so that it may be known whether any dangerous exposure existed. CAUSE OF DEATH

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63891

CERTIFICATE OF DEATH.

179 D, 63891

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 5342 N. Eden ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Young

(a) RESIDENCE. NO. 2534 N Eden ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 60 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wash Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Md

PARENTS

10 NAME OF FATHER: Henry Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: George Ellis
(Address): 2534 N. Eden St

15 Filed MAY 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/28 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1922, to April 28, 1922, that I last saw h.er alive on April 27, 1922, and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

To my Knowledge (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physicial + Lab

(Signed) R J Young, M. D.

, 19 (Address) 1729 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loyler Park Md

DATE OF BURIAL: May 2 19

20 UNDERTAKER: R C Gross

ADDRESS: 1405 McElderry

mation should be given in plain terms, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

M. C.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63892

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 528 E 23rd St. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Cleary

(a) RESIDENCE. No. 528 E 23rd St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Cleary

6 DATE OF BIRTH (month, day, and year) July 21st 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dublin Ireland

PARENTS

10 NAME OF FATHER Patrick Meara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Meara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs E J Brinnegan

(Address) 528 E 23rd St

15 Filed MAY 1 1922 Registrar

167 W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 29th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 18th, 1922, to April 29th, 1922.

That I last saw her alive on April 29th, 1922

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. Wallace Long M.D. M. D.

4/29/22 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 5/2/22

UNDERTAKER: Chas H Evans & Son — ADDRESS: 1180 Mt Royal Ave

NOTE—WRITE mation should be carefully supplied. AGE should be given CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~93893~~ 71-001 D 63893

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hospital WARD ST., 14 WARD)

2-FULL NAME Mrs. Mary Dorworth.

(a) RESIDENCE NO. R.F.D. Hydes, Balto Co. Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced (HUSBAND) of (or) ~~WIFE~~ of Wm J. Dorworth.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Greensboro, N.C.
(State or country)

PARENTS

10 NAME OF FATHER Wm D. Cator

11 BIRTHPLACE OF FATHER (city or town) Hanford Co
(State or country) ~~Ireland~~ Va.

12 MAIDEN NAME OF MOTHER Annie Street.

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Georgia

14 Informant Mrs. Caroline Taylor Brown
(Address) 3420 Newark st. Cleveland O.

15 Filed MAY 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1922, to April 30, 1922,

that I last saw h~~er~~ alive on April 30, 1922,

and that death occurred, on the date stated above, at 6 00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis
c cardiac failure.

OTEN

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Leslie E Mayer M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N. C.

DATE OF BURIAL May 1st 1922

20 UNDERTAKER Henry W. Jenkins & Son Co

ADDRESS Richard and Eutaw

N. B.—Answers should be carefully supplied. Abbreviations may be properly classified. Exact information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

63894

HEALTH DEPARTMENT—CITY OF BALTIMORE

63894

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N. Durham St., 18 WARD)

2-FULL NAME Caroline A. Howard

(a) RESIDENCE NO. 1707 N. Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late William A. Howard

6 DATE OF BIRTH (month, day, and year) 3/15/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER John Apps.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant L. Hays (Address) 1707 N. Durham St.

15 Filed MAY 1 1922, 19 Registrar

M & C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1922, to April 29, 1922 that I last saw h[illegible] alive on April 27, 1922 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Mitral incompetency

Decompensation

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Phys. signs —

(Signed) Chas. J. Kellam M. D.

April 19 22 (Address) 332 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 1 1922
20 UNDERTAKER	ADDRESS
Geo. J. Roth	1735 Hoyard Ave.

N. B.—[illegible] mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

B 63895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 B 63895

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Dy Hospital ST., 15 WARD)

2-FULL NAME Jane Holden

(a) RESIDENCE NO. 2330 Reisterstown Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Holden,

6 DATE OF BIRTH (month, day, and year) 1884 -

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	-	-	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Domestic Duties

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jack Groves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md,

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jack Groves (Address) Westminster Md

15 Filed MAY 1 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1- 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr-23, 1922, to May - 1 - 1922, that I last saw her alive on May - 1 - 1922, and that death occurred, on the date stated above, at 12 25 A m.

The CAUSE OF DEATH* was as follows:

Multiple Fibroids of Uterus

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/24/22

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Newton J. Owen, M. D.

5/1, 1922 (Address) Franklin Dy. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ed Johns Cemetery	May 19
20 UNDERTAKER S. M. Starr	ADDRESS Ellicott City

N. B.—WRITE plainly and carefully supplied. Any information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63896

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Washington Blvd ST.) (5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche G. Stanislawski

(a) RESIDENCE. NO. 2105 Washington Blvd ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Walter J. Stanislawski

6 DATE OF BIRTH (month, day, and year) Sept — 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Robert Wilson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Arnold

13 BIRTHPLACE OF MOTHER (city or town) Balto, (State or country) Md

14 Informant Mr. Robert Wilson (Address) 2105 Washington Blvd

15 Filed , 19 MAY 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1921, to April 29, 1922, that I last saw h alive on April 22, 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (General)

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Debilitation of Senility (duration) no yrs. no mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Symptoms.

Signed Robert Wilson, M. D.

April 25, 1922 (Address) Residence

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL April 29 1922

20 UNDERTAKER Jos Joerdens & Son — ADDRESS 2175 Rec

mation should be carefully supplied. And ... may be properly classified. Exact statement
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

63897

HEALTH DEPARTMENT—CITY OF BALTIMORE

63897

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 505 N Ellwood St.; 7 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R Sadler

(Residence in Baltimore: No. 505 N Ellwood St.; yrs. 16 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, March (Month) 23 (Day), 1863 (Year)

7-AGE. (59) 60 yrs. 1 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas Sadler

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John R Sadler

(Address) 505 N. Ellwood Ave.

15- MAY 1 - 1922

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 29 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. Kirk Slater M. D.
(Coroner.)

4-29-22, 191.. (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Filgrimans Island Va	May 2, 19 22
20-UNDERTAKER	ADDRESS
Lilly & Ziegler	403 S Wolfe St.

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ..... important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE 63898

CERTIFICATE OF DEATH.

REGISTERED No. C 179

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 14 Gs Hospital ST.; 6 WARD)

2-FULL NAME Barbara Lazowski

(Residence in Baltimore: No. 19 n Wolf St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, March 26, 1917.
(Month) (Day) (Year)

7-AGE, 5 yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Walter Lozauski

11-BIRTHPLACE OF FATHER (State or Country), Austria.

12-MAIDEN NAME OF MOTHER, Balbina Styfand

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Balbina Lozauski

(Address) 19 N. Wolfe St

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, whole body

Immediate

Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem.

DATE OF BURIAL, May 1, 1922

20-UNDERTAKER Lilly and Zulu

ADDRESS 403 S Wolfe St.

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Registered case
of pulmonary tbc.
U Nursing Division

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63899

D 63899

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 E Fairmount Ave ST., 6 WARD)

2-FULL NAME Mary B. Raffle

(a) RESIDENCE NO. 2226 E Fairmount ave ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clinton B. Raffle.

6 DATE OF BIRTH (month, day, and year) Dec 11 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Beckel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Mehlhorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clinton B. Raffle

(Address) 2226 E Fairmount Ave

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1922, to April 29, 1922, that I last saw her alive on April 29, 1922, and that death occurred, on the date stated above, at 7 49 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) Chronic yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2226 Fairmount Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Meyer Ephraim M. D.

19 (Address) 1904 E Bet St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL May 1 1922

20 UNDERTAKER Lilly-Zeiler

ADDRESS 4033 Hoffman

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63900

D 63900

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH US. VETERANS' HOSPITAL #56

CITY OF BALTIMORE: (No. FORT MCHENRY MD. ST., 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DORSEY CARTER.

(a) RESIDENCE NO. US. VETERANS' HOSPITAL #56 ST., 39 WARD FT. McHenry Md.
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22 yrs.	--	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman. D 86
(b) General nature of industry, business, or establishment in which employed (or employer) ----
(c) Name of employer --------

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) UnKnown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rosenbrock (Registrar
(Address) US. V. Hosp. #56 Ft McHenry Md.

15 Filed MAY 1 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1921, to April 30, 1922,
that I last saw him alive on April 30, 1922,
and that death occurred, on the date stated above, at 1'30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary mod. adv. & active. Tuberculosis abscess of spine.

-------- (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ----- (duration) -- yrs. -- mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No.

What test confirmed diagnosis? Clinic report.

(Signed) [illegible] Surgeon US.P.H.S. M. D.
4/30, 1922 (Address) US. Veterans' Hosp. Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. DATE OF BURIAL May 1st 1922

20 UNDERTAKER Harry H. Hobbs ADDRESS 1531 N. Lombard St

N. B.—Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

63901

HEALTH DEPARTMENT—CITY OF BALTIMORE

63901

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Guilford ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Unkel

(Residence in Baltimore: No. 2914 Guilford ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Nov 18, 1856
(Month) (Day) (Year)

7-AGE, 65 yrs. 5 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Butcher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Henriette Unkel

(Address) 2914 Guilford ave

15- Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 16 1922, to April 28 1922, that I saw ~~him~~ alive on April 26 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos J Tillbury M. D.

April 28, 1922 (Address) 415 Cedar Croft Road.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Dulle Cemetery — DATE OF BURIAL. May 1, 1922

20-UNDERTAKER Ed Lanning & Son — ADDRESS 1938 E Lafayette ave

N. B.—Every item must be filled in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

63902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D 63902

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., ... WARD)

2-FULL NAME Margaret Teresa Mc Glinchey

(a) RESIDENCE NO. 8 E. Mulberry St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE Years 75 yrs. Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country) Do not know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Mrs. Anna Lawlor (Address) 8 E Mulberry St

15 Filed MAY 7 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-29 1922 to 4-30- 1922, that I last saw her alive on 4-30- 1922 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acidosis.

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Starvation

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. W. Scott M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/3 1922

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

N. B.—WRITE plainly. ALL information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Narration due to refusal Deat

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Deceased living by herself. About Christmas became invalided in bed. Neighbor visited her & one day when nurse came she found her in coma. Sent to hospt. in unconscious condition & died next day. No further history

63903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63903

143-001

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 205 S. Castle St., 2 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Chase
(Residence in Baltimore: No. 205 S. Castle St.; yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.
4-COLOR OR RACE: White
5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH. Nov (Month) Known (Day) 1 (Year)

7-AGE: 28 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Balto.

PARENTS.
10-NAME OF FATHER: Henry Chase.
11-BIRTHPLACE OF FATHER. (State or Country): Md.
12-MAIDEN NAME OF MOTHER: —
13-BIRTHPLACE OF MOTHER. (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Eugene Parks
(Address) 205 S. Castle St.

15-
Filed MAY 1 - 1922 19..
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: April (Month) 29 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Inquiry autopsy or Inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Abortion Incidental
(Duration) yrs. mos. ds.
(Signed) G E Grady M. D.
(Coroner)
192. (Address) 1132 N. Paca

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Trinity Cemetery
DATE OF BURIAL: 5-1st 19 22
20-UNDERTAKER: J. A. Moran
ADDRESS 3000 E. Balto St.

N. B.—Every item of information must be given as accurately as possible, in order that it may be properly recorded on this certificate. State CAUSE OF DEATH in plain terms, so that it may be understood by a layman. See instructions on back of certificate. The date of burial is very important.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various occupations can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis.*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 63904 ✓ D 63904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Presstman ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Johnson

(a) RESIDENCE NO. 1618 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married

6 DATE OF BIRTH (month, day, and year): [illegible] 1876

7 AGE: Years 26 (45?) Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: labor

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): m. d

PARENTS

10 NAME OF FATHER: Richard Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): m. d

12 MAIDEN NAME OF MOTHER: mary ialley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): m d

14 Informant: mary ialley mother (Address) 1618 Presstman 1922 st

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1922. to April 29, 1922.

that I last saw him alive on April 28, 1922.

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy + Haemorrhage of Lung.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia + Tuberculosis of Lung. (duration) yrs. 4 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. G. W. Kommael M. D.

4-29. 1922 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt auBurn Cemetery — DATE OF BURIAL: may 2 19 22

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans St

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63905

CERTIFICATE OF DEATH.

117

REGISTERED NO.....

1-PLACE OF DEATH Lily

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lilly Stillmann

(a) RESIDENCE NO. Severn apts City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Stillmann

6 DATE OF BIRTH (month, day, and year) 1866-12-10.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Malloy

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Sarah Kenneth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward Stillman

(Address) Severn apts Baltimore

15 MAY 1 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1922 to April 30, 1922

that I last saw her alive on April 30, 1922

and that death occurred, on the date stated above, at 5 45 p m.

The CAUSE OF DEATH* was as follows:

General Peritonitis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) acute appendicitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted, if not at place of death? Severn apts Balto Md

Did an operation precede death? yes Date of April 2, 1922

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E L Duncan M. D.

(Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL May 2 1922

20 UNDERTAKER Henry H Jenkins Sons.

ADDRESS McCulloh & Eastern

mation should be carefully supplied. How to fill out CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Early attention to this subject is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 63906

CERTIFICATE OF DEATH.

181 D 63906

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1040 Mc Donough St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elzobeth Baincker

(Residence in Baltimore: No. 1040 mc Donough St. St.; yrs., 68 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fmale

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March 23, 1 (Month) (Day) (Year)

7-AGE 65 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Enoch G. Lee

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Barto

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs O Mowell

(Address) 1040 Mc Donough St

15-

Filed MAY 1 1922 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) H A Harlan M. D. (Coroner.)

4-29, 1922 (Address) U.S. Ent

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, May 2, 1922

20-UNDERTAKER Henry Lutz — ADDRESS 1203 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63907

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2316 E. Baltimore ST.; 6 WARD)

2-FULL NAME Laura Beck

(a) RESIDENCE. NO. 2316 E. Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Lotenzock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Umlauff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lenz (Address) 2316 E. Baltimore St.

15 Filed MAY 1 - 1922 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1st/21, 19.., to April 29, 1922, that I last saw her alive on April 29, 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ~ Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb N. Potter, M. D.

May 1st 1922 (Address) 100 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL May 1 1922

20 UNDERTAKER Josiah Syfer — ADDRESS 160 W. Mulberry St

Be properly classified. CAUSE OF DEATH in plain terms, so that it may be of certificates. TION is very important. See instructions on back of c

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63908

D 63908

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4022 Belle Ave ST., 15 WARD)

2-FULL NAME Samuel Stehley Sr

(a) RESIDENCE NO. 4022 Belle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A Stehley

6 DATE OF BIRTH (month, day, and year): June 27 1853

7 AGE: Years 68, Months 10, Days 7. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harrisburg Pa

PARENTS

10 NAME OF FATHER: Samuel Stehley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harrisburg Pa

12 MAIDEN NAME OF MOTHER: Mary G Zittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harrisburg Pa

14 Informant (Address): Mary A Stehley 4022 Belle ave

15 Robert F. Harrison, Registrar

MAY 1 - 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to April 29, 1922, that I last saw him alive on April 28, 1922, and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. H. Dyer M. D.

4/30 1922 (Address) 3501 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: May 2 1922

20 UNDERTAKER: Wolff & Burns

ADDRESS 1442 W Broadway

mation should be entered, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63909

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2-FULL NAME Mamie Proctor.

(a) RESIDENCE NO. 1117 W. Mt. Elderry St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced, (HUSBAND of) (or) WIFE of: Charles Proctor (Maryland)

6 DATE OF BIRTH (month, day, and year): Dec 22, 1883

7 AGE: Years 37 | Months 4 | Days 4 | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profesalon or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Will Hadnick.

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ?

12 MAIDEN NAME OF MOTHER: Martha Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant ..... (Address) .....

15 Apr 27 1922 . 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26 1922

17

I HEREBY CERTIFY, That I attended deceased from April 23. 1922. to April 26. 1922.

that I last saw h[illegible] alive on April 26. 1922

and that death occurred, on the date stated above, at 9.55 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

Arteriosclerosis—myocardial degeneration

(duration) About 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 4 5 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Francis R. Dieuaide, M. D.

Apr. 26, 1922 Address: Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ..... DATE OF BURIAL ..... 19 .....

20 UNDERTAKER ..... ADDRESS .....

mation should be entirely supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Czapski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63910

113 D 63910

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) NO. 5045 Montford Ave ST.; 2 WARD)

2-FULL NAME Paul Theodore Czapski

(a) RESIDENCE. NO. 5045 Montford Ave ST. WARD. 2

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	W.	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10-1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	16 mos.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Paul Czapski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Wojtasak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr Paul Czapski (Address) 5045 Montford Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1- 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1922 to 5-1- 1922

that I last saw h alive on 4-30 1922

and that death occurred, on the date stated above, at 7 A' m.

The CAUSE OF DEATH* was as follows:

Ulcerative Stomatitis.

anemia (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) T T [illegible] M. D.

1922 Address) 800 Matt Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	May 2- 1922
20 UNDERTAKER M. J. Lodowski.	ADDRESS 705 S. Ann St

MAY 1 - 1922

MATION SHOULD BE GIVEN IN PLAIN TERMS, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63911

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 S. Kenwood Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Battejewske

(a) RESIDENCE. NO. 839 S. Kenwood ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Battejewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

11 Informant Frank Battejewski

(Address) 839 S Kenwood Ave

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30th 1922

17 I HEREBY CERTIFY, That I attended deceased from Feby 1st, 1922, to April 30th, 1922, that I last saw him alive on April 29th, 1922, and that death occurred, on the date stated above, at 9-40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Caleb N. Athey, M. D.

May 1, 1922 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	May 3 1922
20 UNDERTAKER	ADDRESS
M. J. Sadowski	705 S Ann St

mation should be carefully written in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Burial Permit Issued

1922

Spec.—1-10-21—M&T—1500 Bks.

(Gutman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63912

CERTIFICATE OF DEATH.

D 63912

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 571 N. Exeter ST., 5 WARD)

2-FULL NAME Edward J Gutman

(a) RESIDENCE NO. 571 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Can Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Gutman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mary Gutman (Address) 571 N Exeter

15 Filed May 1 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1922, to Apr 30, 1922

that I last saw h. alive on Apr 30, 1922

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Carroll Ashmead M. D.

May 1922 (Address) 1334 - Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL May 2 1922

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1706 Eastern Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

1-1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter. Physician, Compositor, Architect, Locomotive engineer, Civil engineer. Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook. Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

May hold funeral tomorrow (May 2)
Epidemic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63913

D 63913

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 W. Montgomery ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Brooks

(a) RESIDENCE. No. 112 W. Montgomery ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of David Brooks

6 DATE OF BIRTH (month, day, and year) —— 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Virginia

PARENTS

10 NAME OF FATHER Wallie Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Annie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Virgie Brooks
(Address) 112 W. Montgomery

15 Filed Robert F. Harrison Registrar

MAY 1 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1922, to Apr. 29, 1922.

that I last saw her alive on Apr. 29, 1922.

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. myocarditis & nephritis (duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dan Drambain M. D.

5/1, 1922 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 2 1922
20 UNDERTAKER David Eagle	ADDRESS 915

Make Statements in this column in plain terms, so that it may be properly CODED. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D 63914

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 63914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Hull St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amalia Knoch

(a) RESIDENCE NO. 1104 Hull ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of late Franz Knoch

6 DATE OF BIRTH (month, day, and year) Nov 30-41

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	80	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Heine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adelheid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie Knoch

(Address) 1104 Hull St

15 ROBERT P. MATTHEWS, Burial Permit Clerk. Registrar

MAY 1 - 1922

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28, 19 22, to April 29, 19 22,

that I last saw h W alive on April 29, 19 22,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pastian failure

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Valv. Heart disease

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt. P. Schmidt, M. D.

April 29 19 22 (Address) 1318 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cem. DATE OF BURIAL 5/2 1922

20 UNDERTAKER Philip Herwig ADDRESS 2016 Aisquith

Spec.—1-10-21—M&T—1500 Bks.

D 63915 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63915

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Church Home & Inf 6 — REGISTERED NO.

CITY OF BALTIMORE: (No. 815 Broadway ST., Fairmount WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louisa T. Blanchard

(a) RESIDENCE NO. Fairmount ave, ST., Raspeburg Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ of Louisa Blanchard

6 DATE OF BIRTH (month, day, and year) July 27-46

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	75	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship builder

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New England

PARENTS

10 NAME OF FATHER Wm Blanchard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) cc q

14 Informant Louisa T Blanchard (Address) Fairview (or) Raspeburg

15 Robert F. Harrison 19 Burial Permit Clerk Registrar

MAY 1-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/29/, 1922, to 4/30/, 1922, that I last saw h.. alive on 4/30/, 1922, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Chronic Interstitial Nephritis

Edema Lungs

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Myocarditis (duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Gaetano Lanciotti, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL 5/2 1922

ADDRESS 2016 Orleans

20 UNDERTAKER Philip Henry

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

(Beatin)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63916

CERTIFICATE OF DEATH.

118-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Calderine Beatin

(a) RESIDENCE. NO. 702 E. Hoover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of → Edward Beatin

6 DATE OF BIRTH (month, day, and year) Jan. 4, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Burfey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mercy Hospital Records (Address)

15 Filed Apr 29, 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1922, to Apr 29, 1922 that I last saw her alive on Apr. 29, 1922 and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia

(duration) yrs 4 mos. 5 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of Apr 24, '22

Was there an autopsy? No

What test confirmed diagnosis? Pathological Symptoms & Symptoms

(Signed) John L. Brown, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 1 1922
20 UNDERTAKER John A. Moran	ADDRESS 3000 E. Baltimore St.

mation should be carefully written in ink, so that it may be properly examined.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

NY 1 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63917 129 D 63917

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2343 Frederick Ave. ST., 20 WARD)

2-FULL NAME Mary Jane Moran

(a) RESIDENCE NO. 2343 Frederick Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Moran

6 DATE OF BIRTH (month, day, and year) Aug. 13th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Granite Balto. Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Litchfield

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Edward J. Moran
(Address) 2343 Frederick Ave.

15 MAY 1 1922, 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30th 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1922, to Apr 30, 1922, that I last saw h alive on April 30, 1922, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) chronic interstitial nephritis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Walter A. Bloom, M. D.

May 1, 19 22 (Address) 541 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL May 3rd 1922

20 UNDERTAKER Joseph L. B. Cook ADDRESS 1003 N. Balto St

MAY 1 - 1922

Mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 63918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63918

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 718 N Caroline ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Brown

(Residence in Baltimore: No. 718 N Caroline St.; yrs., 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Mal

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widower

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE: 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie B. Brown

(Address) 718 N. Caroline St.

15-

Filed ....., 191.. MAY 2 - 1922 ..... Registrar.

14 C.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Klee Judge M. D.
(Coroner)

May 2, 1922. (Address) 1502 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Asbury — DATE OF BURIAL, May 2, 1922

20-UNDERTAKER John W Henderson — ADDRESS 1502 E Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 63919

D 63919

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Wayne ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Cornish

(a) RESIDENCE NO. 604 Wayne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Cornish

6 DATE OF BIRTH (month, day, and year) [illegible] 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lloyd Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Caroline Cornish (Address) 604 Wayne St

15 Filed MAY 2 - 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1922, to Apr 29, 1922, that I last saw h[illegible] alive on April 28, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

May 1 1922 (Address) 917 S. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL May 2 1922

20 UNDERTAKER John H. Toadvine

ADDRESS 142 Ashland Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63920

CERTIFICATE OF DEATH.

D 63920

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Pennyton St.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Sadow

(Residence in Baltimore: No. 922 Pennyton ave St.; ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 22 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Stanislaw Sadow

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Helen Grabowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaw Sadow

(Address) 922 Pennyton ave.

MAY 2 - 1922

15- Filed ....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 30, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1921, to Apr 30 1922 that I saw her alive on Apr 30 1922 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Acute Mitro Cordetis

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Defection

(Duration) ... yrs. 6 mos. ... ds.

(Signed) ... M. D.

May 1, 1922 (Address) 1340 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, May 3, 1922

20-UNDERTAKER Dade Fiat Lux Co. ADDRESS 1516 Bond St

N. B. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Bad teeth and tonsils primary infection

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis*,	*Childbirth*,	*Convulsions*,
Hæmorrhage,	*Gastritis*,	*Erysipelas*,	*Meningitis*,
Gangrene,	*Miscarriage*,	*Necrosis*,	*Peritonitis*,
Phlebitis,	*Pyæmia*,	*Septicæmia*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D 63921

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63921

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 8 E. Hamburg ST., 23 WARD)

2-FULL NAME Mary E Bevans

(a) RESIDENCE NO. 8 E Hamburg ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer R Bevans

6 DATE OF BIRTH (month, day, and year) Sept 23 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norwich Conn.

PARENTS

10 NAME OF FATHER John A Potter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norwich Conn.

12 MAIDEN NAME OF MOTHER Sarah Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norwich Conn

14 Informant Arthur R Bevans (Address) 602 McCabe Ave

15 Filed MAY 2 1922 J H Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-30-22 to 4-30-1922, that I last saw h w alive on 4-30-22, 19 ..., and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ... yrs. ... mos. 2 hrs

CONTRIBUTORY (Secondary) Chronic nephritis

Hypertension (duration) 8 yrs. ... mos. ... ds.

18 Where ~~was disease contracted~~ if not at ~~place~~ of death? Patient known about 5 months

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? usual clinical symptoms

(Signed) James Brown, M. D.

, 19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 4 1922
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

N. B. ... mation should be carefully supplied. ... it may be properly classified. ... CAUSE OF DEATH in plain terms, so that it ... TION is very imprtant. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63922

REGISTERED NO. D 63922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Ridgley St. Mt. Winans ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anderson Williams

(a) RESIDENCE. NO. Mt. Winans ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jennie Williams

6 DATE OF BIRTH (month, day, and year): June 25, 1866

7 AGE: Years 55 Months 10 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ala.

PARENTS

10 NAME OF FATHER: Thomas Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ala.

12 MAIDEN NAME OF MOTHER: Mary Hollins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alabama

14 Informant (Address): Jennie Williams Mt Winans

15 Filed MAY 2 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/10/, 1922, to 4/30/, 1922, that I last saw him alive on 4/29/, 1922, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

Nephritis 7 mos.

(duration)

CONTRIBUTORY (Secondary) Syphilis (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopy

(Signed) J. B. Hawkins M. D.

(Address) 1216 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: May 2 1922

20 UNDERTAKER: Wm. Scott Hooper — ADDRESS: 706 W. Lanvale St.

Filed May 2 1922

Information should be carefully supplied, so that it may be properly classified. Physicians are requested to report CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63923

CERTIFICATE OF DEATH.

90D 63923

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3013 O'Donnell ST., 1 WARD)

2-FULL NAME Thelma L. Betz

(a) RESIDENCE NO. 3013 O'Donnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Jan. 15- 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Amer. Wholesale Corp.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John C. Betz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Julia A. Lidard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Julia A. Betz

(Address) 3013 O'Donnell St.

15 Filed MAY 2 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to April 30, 1922, that I last saw her alive on April 30, 1922, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) [illegible] M. D.

5/1, 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery DATE OF BURIAL May 3 1922

20 UNDERTAKER Zirkler + Zirkler ADDRESS 1739 Eager

N. B. ... mation should be carefully supplied. ... may be properly classified. EXACT statements CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

63924

HEALTH DEPARTMENT—CITY OF BALTIMORE

63924

CERTIFICATE OF DEATH.

431

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 610 E. Pratt. ST.: 4 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Steitz

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	unknown

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE. 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ? 887
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). unknown

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER .....

13-BIRTHPLACE OF MOTHER (State or Country). .....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed MAY 2 - 1922 191.... Registrar.

MD 9.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. dis. heart

Duration unknown, he had rheumatism

Tuberculosis (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary) Sudden (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. T. Riley M. D.
(Coroner.)

April 21, 1922. (Address) 1617 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem. DATE OF BURIAL, May 3, 1922

20-UNDERTAKER Harry W. Perkins & Son Co. ADDRESS McCulloh & Orchard

N. B.—Every item of information should be carefully supplied. ACCURATE AND COMPLETE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION IS VERY important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

63925

REGISTERED NO. 101 - D 63925

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Wheeler Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorris Hood

(a) RESIDENCE. NO. 30 Wheeler Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas. L. Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florance Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas. L. Hood
(Address) 30 Wheeler Ave

15 Filed MAY 2 - 1922, 19 Registrar

M-70

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1. 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 30, 19 22, to May 1, 19 22, that I last saw h[illegible] alive on May 1, 19 22, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH was as follows*

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph A Zurlo M. D.

. 19 (Address) 1423 Eaglestone

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL May 4 1922

20 UNDERTAKER George Schmad ADDRESS 2101 Eutaw ave

Information should be carefully supplied, so that it may be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be of use in the Bureau of Vital Statistics. See instructions on back of certificates. ATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63926

CERTIFICATE OF DEATH.

10 D 63926

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 Division St ST., 14 WARD)

2-FULL NAME Anna G Savage.

(a) RESIDENCE NO. 1507 Division St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) July 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Joseph B Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nassawadox Va.

12 MAIDEN NAME OF MOTHER Edith Webb

13 BIRTHPLACE OF MOTHER, (city or town) (State or country) Virginia

14 Informant Jos B Savage (Address) 1507 Division St

15 Filed ....., 19.... Registrar

MAY 2 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/1922

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1922, to May 2, 1922, that I last saw h in alive on May 2, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Infectious Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw J. Wheatley M. D.

5/2/1922 (Address) 1230 S. Hilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 3 19

20 UNDERTAKER E Parsons & Wright — ADDRESS 3649 Keswick

N. B.—WRITE plainly. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Culture proved positive for diphtheria. To be in communicable Disease Dept. records, as case of laryngeal diphtheria.

Spec.—1-10-21—M&T—1500 Bks.

D 63927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63927

CERTIFICATE OF DEATH.

162

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST., 12 WARD)

2-FULL NAME Baby Siemonn

(a) RESIDENCE NO. 103 W. 39th St Balto WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2 1922

7 AGE — Years — Months — Days

If LESS than 1 day, ...hrs. or 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER J. George Siemonn.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Mabel Garrison.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md

14 Informant J.G. Siemonn. (Address) 103 W 39th St

15 Filed MAY 2 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1922 to May 2, 1922

that I last saw her alive on May 2 1922,

and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:

Uterine Asphyxia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Leslie E Myall M. D.

, 19 (Address) Womans Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL May 2 1922

20 UNDERTAKER J. C. Wiedefeld 9-14

ADDRESS Greenmount Ave

N. B.—WRITE PLAINLY, with ink. All information required should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 63928

HEALTH DEPARTMENT—CITY OF BALTIMORE

162

D 63928

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 W Lee ST., 22 WARD)

2-FULL NAME Margaret F. King

(a) RESIDENCE NO. 18 W. Lee ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 13-22

7 AGE: Years — Months — Days 18 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ood

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas E. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Novacle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary King
(Address) [illegible]

15 MAY 2-1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 13, 1922, to May 1, 1922, that I last saw her alive on May 1, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemmorrhage
(Shock, Rectal Hemmorrhage)
over

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) — (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no. Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? .....

(Signed) Wm Svanstrom M. D.

5/2, 1922 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rosary Cem.

DATE OF BURIAL: May 2 1922

20 UNDERTAKER: F.A. Krause & Son

ADDRESS: 1039 Hanover

N. B. ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infantile visceral hemorrhage.
No injury at birth.
No congenital trouble

Spec. (1500 Bks.)

D 63929

(Frederick Lee Parker)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 63929

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospl ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank L Parker

(a) RESIDENCE NO. 701 Regent Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Parker

6 DATE OF BIRTH (month, day, and year) 11/24/80

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie Rowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mollie S. Parker (Address) 701 Regent Ave

15 MAY 2 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/22 19

17 I HEREBY CERTIFY, That I attended deceased from 4/26/22, 19..., to 5/2/22 19...,

that I last saw he alive on 5/2/22, 19..., and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) 11+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symp

(Signed) John A Foreman M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn C

DATE OF BURIAL May 4 19 22

20 UNDERTAKER A S Marshall 3539 Edmondson Ave

ADDRESS

N. B.—WRITE PLAINLY, with ink. All items must be stated. AGE should be carefully supplied. Exact statement of occupation should be carefully supplied, so that it may be properly classified. AGE should be stated in plain terms, so that it may be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 63930

63930

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Howard A. Kelly Hospital

CITY OF BALTIMORE: (NO. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bertha N. Kingsbury

(a) RESIDENCE. NO. Xenia, Ohio ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert S. Kingsbury

6 DATE OF BIRTH (month, day, and year) May 26 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	11	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Xenia Ohio

PARENTS

10 NAME OF FATHER Edward Nesbitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Xenia Ohio

12 MAIDEN NAME OF MOTHER Sarah Trees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Xenia Ohio

14 Informant Robert S. Kingsbury (Address) Xenia Ohio

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1922, to May 1, 1922, that I last saw h.. alive on May 1, 1922 and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism.

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Adenocarcinoma rectum

* Fecal fistula (duration) 7 yrs.? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Jan. 20, 1922

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Arthur C. Peterson, M. D.

5/1/1922 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Xenia Ohio	May 2 1922

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. Fayette

M.7.A. [redacted] 9-1922

N. B.—WRITE PLAINLY. All items should be carefully supplied. Any information should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63931

CERTIFICATE OF DEATH.

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1226 Patapsco St. 23 (Ward)

2-FULL NAME Dalsta M. Balsamo

(a) RESIDENCE. No. 1226 Patapsco St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fruit Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Pietro Balsamo

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Bova

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Peter Balsamo
(Address) 1226 Patapsco St

15 Filed ..... 19.. Registrar

MAY 2 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1922, to April 30, 1922, that I last saw h... alive on April 30, 1922, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E. Valentine, M. D.

(Address) 1226 Patapsco St April 30, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	5-3rd 1922
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Baltimore Hollins st

information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63932

CERTIFICATE OF DEATH.

1922

REGISTERED NO. D 63932

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsby Carter

(a) RESIDENCE. NO. Bay View Asylum. ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 71 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed MAY 2 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1922

17 I HEREBY CERTIFY, That I attended deceased from October 10 . 1921 . to April 27 . 1922.

that I last saw him alive on April 27 . 1922.

and that death occurred, on the date stated above, at 11:30 P M.

The CAUSE OF DEATH* was as follows:

Essential Hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alpheus Hall, M. D.

4/29/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL May 2 1922

20 UNDERTAKER Henry Hoerdt Son

ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be stated EXACTLY. Exact statement of years, months and days of AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of years, months and days of AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

D 63933 HEALTH DEPARTMENT—CITY OF BALTIMORE 002 D 63933

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE (No. 819 So. Montford Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Ponaszewski

(Residence in Baltimore: No. 819 So. Montford Ave — St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... May (Month) 1st (Day), 1922 (Year)

7-AGE, ... yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or 8 min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto, md

PARENTS.

10-NAME OF FATHER. John Ponaszewski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Josephine Poloch

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jamies Ponaszewski

(Address).....

15- Robert P. Harrison,

Filed ....., 191.....

AY 2 - 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 1st (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... Inquest ... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ... Inquest ... (Inquest, autopsy or inquiry.) find that said deceased came to ... his ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Strangulation Cord around neck several times

..... Duration ..... In labor 1 hour

CONTRIBUTORY (Secondary) child lived 5 minutes

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ... Thos. B. Horton ... M. D.
(Coroner.)

May 2 1922 (Address) Curtis Bay, Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	May 2, 1922
20-UNDERTAKER	**ADDRESS**
John M. Weber	1803 Bank

8.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63934

CERTIFICATE OF DEATH.

90 D 63934

REGISTERED NO.....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Charles & Read St Lotrobe Apt ST.: [redacted] WARD)

2-FULL NAME Frances Starr Martin

(a) RESIDENCE. NO. Charles & Read ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~ Widowed, or ~~Divorced~~ (write the word): Widowed

5a If ~~married~~ widowed, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5th 1858

7 AGE — Years: 64 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: F. Robert Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: M. F. Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Miss Marton Lotrobe Apt

15 Filed ..... 19 ..... Registrar

MAY 2 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Apl 1921, to May 1922, that I last saw h[illegible] alive on May 1 1922, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

7th Bnn Md Cadets

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) H Warren Buckler, M. D.

19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Maryland

DATE OF BURIAL: May 3rd 1922

20 UNDERTAKER: H Weideius & Son

ADDRESS: Eutaw & Mc Culloh Sts

Information should be carefully supplied. All items should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of CAUSE OF DEATH in plain terms, so that it may be of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 63935

CERTIFICATE OF DEATH.

13 D 63935

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Hakesley Place St., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredrick Hundertmark

(Residence in Baltimore: No. 1637 Hakesley Place St.; 42 yrs., X mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, SEP (Month) 24 (Day), 1852 (Year)

7-AGE, 69 yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor 80
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Fredk Hundertmark

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Hundertmark

(Address) 1637 Hakesley Place

15-

Filed....., 191..... Robert P. Harrison, Registrar.

MAY 2 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, MAY (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Ap 22 1922, to Ap 30 1922, that I saw h/M alive on Ap 30 1922, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(Duration) 8 yrs. X mos. X ds.

(Signed) D. H. Burket M. D.

MAY 1 1922, 191... (Address) 928 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Western Cemetery

DATE OF BURIAL, May 3 1922

20-UNDERTAKER Geo C. Miller

ADDRESS 2334 Jefferson St

Every item of information should be entered, so that it may be properly classified. Write CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63936

D 63936

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 S. Green ST.: 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Hinton

(a) RESIDENCE. No. 508 S. Green ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common Laborer

(c) Name of employer Albert Popkins

9 BIRTHPLACE (city or town) (State or country) Fort Valley Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Robert L. Harrison,

15 Burial Permit Clerk. Registrar

MAY 2 - 1922

THE MORGUE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23rd, 1922, to Apr 25th, 1922, that I last saw him alive on Apr 25th, 1922, and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Currie M. D.

4/29, 1922 (Address) 1400 Mill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19 MAY 2 1922

20 UNDERTAKER Commissioner Health

ADDRESS

—WRITE PLAINLY, WITH UNFADING INK. All items must be stated. Exact statement of information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

body at city morgue

D 63937 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63937

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 839 Rabory st ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2-FULL NAME Jno Smith

(Residence in Baltimore, No. 839 Rabory st — St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 50 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, ( )

11-BIRTHPLACE OF FATHER (State or Country), ( )

12-MAIDEN NAME OF MOTHER ( )

13-BIRTHPLACE OF MOTHER (State or Country), ( )

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Robert F. Harrison, ..., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 25, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy~~ or inquiry.) thereon and from the evidence obtained by said (~~Inquest~~, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H. K. Jamison M. D. (Coroner.)

4-30, 1922 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND, DATE OF BURIAL, ..., 19....

20-UNDERTAKER THE MORGUE. ADDRESS 2 1922

MAY 2 - 1922

144

N.B. Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WI... MARG...

Body at city morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63938

CERTIFICATE OF DEATH.

D 63938

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 825 Raborg st - St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Jenkins

(Residence in Baltimore: No. 825 Raborg st - St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	col.	Dont Know

6-DATE OF BIRTH, ... Dont Know (Month) ..... (Day) ; 1 ..... (Year)

7-AGE, 60 about yrs. ..... mos. ..... dys.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... yard

9-BIRTHPLACE. (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, - - -

11-BIRTHPLACE OF FATHER (State or Country), - - -

12-MAIDEN NAME OF MOTHER - - -

13-BIRTHPLACE OF MOTHER (State or Country), - - -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Robert P. Hartson, ..., 191.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Apl (Month) ..... 26 (Day), 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A K Gorsuch M. D. (Coroner.)

4-30, 1912 (Address) 117 W Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ... DATE OF BURIAL, ..., 19....

20-UNDERTAKER ..... ADDRESS .....

Every item of information should be carefully supplied. AGE important. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

4-2-1922

UNIVERSITY OF MARYLAND
Commissioner of Health
THE MORGUE

D 63939 · HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 801 D 63939

D 63939

CERTIFICATE OF DEATH. 19 205 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1520 Ramsey St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Porter

(Residence in Baltimore: No. 1520 Ramsey St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Sgl

6-DATE OF BIRTH. April 22 1922
(Month) (Day) (Year)

7-AGE. .....yrs. 2 mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, John F Porter

11-BIRTHPLACE OF FATHER, (State or Country). Balto city

12-MAIDEN NAME OF MOTHER, Ida Hendricks

13-BIRTHPLACE OF MOTHER, (State or Country). Howard Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Porter

(Address) 1520 Ramsey St

15- Robert P. Harrison, JOHNS

MAY 2 1922 192..... Burial Permit Clerk. Registrar.

THE MOSQUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congestion of Brain
Cause Unknown

(Duration) .....yrs. .....mos. 2 .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) James M Fenton M. D.
(Coroner.)

H 17 192 2 (Address) 700 E Chase St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. HOPKINS HOSPITAL

DATE OF BURIAL. ..... 192.

20-UNDERTAKER. Commissioner Health.

ADDRESS. May 2 1922

Per. Wm. E. WOODALL

—Every item of information should be carefully supplied. Exact statement of cause is very important. See instructions on back of certificate. state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D 63940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63940

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rubie Frey.

(Residence in Baltimore: No. 2625 Greenmount Ave St.; 40 yrs., -- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6-DATE OF BIRTH: Sept. 21, 1873 (Month) (Day) (Year)

7-AGE: 48 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Patrick Ryan

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Do not know

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William W. B. Frey

(Address) 2625 Greenmount Avenue

15- Filed ....., 191.....

Robert P. Garrison, Burial Permit Clerk. Registrar.

APR 2 - 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: April 20th, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from April 2[illegible] 1922, to April 20 1922, that I saw h[illegible] alive on April 20 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Magruder M. D.

....., 191.. (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 6 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence 2625 Greenmount Ave

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: 4/30, 1922

20-UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Willis)

D 63941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63941

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Hilton ST., 70 WARD)

2-FULL NAME James A Willis

(a) RESIDENCE NO. 8 N Hilton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret L.

6 DATE OF BIRTH (month, day, and year): June 15th 1862

7 AGE: Years 59 Months 10 Days 15 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: R.R. Conductor 173

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: B & O R.R. Co.

9 BIRTHPLACE (city or town) (State or country): Easton Md.

PARENTS

10 NAME OF FATHER: William Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant (Address): Mrs. Margaret Willis 8 N. Hilton St.

15 MAY 2 - 1922 , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch. , 1922 , to April 30 , 1922 that I last saw him alive on April 27 , 1922 and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J M Trumpkin, M. D.

May 2 1922 (Address) 826 N Darrall Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 5/3/1922

20 UNDERTAKER: E. D. Fanning & Son 1460 — ADDRESS: Baltimore Co.

B.—WRITE PLAINLY, with indelible pencil. AGE should be stated correctly. Exact statement of DECEASED'S OCCUPATION should be carefully supplied. AGE should be carefully supplied

D 63942

HEALTH DEPARTMENT—CITY OF BALTIMORE

178 D 63942

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 910 W. Lombard ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos H Grunfield

(Residence in Baltimore: No. 311 Scott St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 21 (Day), 1911 (Year)

7-AGE, 10 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thos H Grunfield

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maud E Curry

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas H Grunfeld

(Address) 311 Scott St

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

MAY 2 - 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis from Heating

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ....yrs. ....mos. ....ds.

(Signed) H K Grunal M. D.
(Coroner.)

5-2-, 1922 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, May 5, 1922

20-UNDERTAKER Geo. J. Smith — ADDRESS 1500 W Fayette St

NOTE.—Every item of information should be carefully supplied. AGE should be carefully calculated. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63943

D 63943

CERTIFICATE OF DEATH.

REGISTERED NO. 100.001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 794 W Saratoga ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Carter

(a) RESIDENCE NO. 794 W Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Arthur Carter

11 BIRTHPLACE OF FATHER (city or town) Union Spgs
(State or country) Ala

12 MAIDEN NAME OF MOTHER Mary Lea

13 BIRTHPLACE OF MOTHER (city or town) Union Spgs
(State or country) Ala

14 Informant Arthur Carter
(Address) 794 Saratoga

15 Filed MAY 2 - 1922 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1922 to 5/1, 1922, that I last saw him alive on 5/1, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

over

Broncho Pneumonia 5 ds.
(duration) yrs. mos.

CONTRIBUTORY —
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 656 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 3 1922
20 UNDERTAKER Brandenburg Funeral Service	ADDRESS 1144 W

N. B.—WRITE PLAINLY, with ink. All items should be carefully supplied. AGE should be stated in years, months and days. Exact statement of date of birth is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63944

CERTIFICATE OF DEATH.

152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Parks.

(a) RESIDENCE. NO. 933 S. Linwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept 15th, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Samuel Parks

11 BIRTHPLACE OF FATHER (city or town) Balto., Md. (State or country)

12 MAIDEN NAME OF MOTHER Annie Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md. (State or country)

14 Informant Hospital Records,

(Address) Municipal Hospital.

15 MAY 2 1922 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 8, 19 22, to April 30, 19 22 that I last saw h im alive on April 30, 19 22 and that death occurred, on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH* was as follows:

Carbuncle on back of neck

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Sepsis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 4-9-22

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Brumbock, M. D.

5/1/1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Orrm (Cemetery)	5/3 1922
20 UNDERTAKER	ADDRESS
William Cook	502 E N Ave

—Name should be carefully supplied. AGE should be stated in years. Exact statement of DATE OF BIRTH should be carefully supplied. AGE should be stated in years. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Information should be carefully supplied. AGE should be stated in years. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DATE OF BIRTH is very important. See instructions on back of certificates.

D 63945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63945

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 402 So. 4th St. ST. 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson Tracey

(Residence in Baltimore: No. 402 So. 4th St. Balto St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widower

6-DATE OF BIRTH, June 4th, 1854 (Month) (Day) (Year)

7-AGE, 67 yrs. 10 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Balto Co. Md

PARENTS.

10-NAME OF FATHER: James Tracey

11-BIRTHPLACE OF FATHER (State or Country): Balto. Co Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Shank

(Address) 402 So. 4th St

15- Filed ....., 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2nd, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner)

May 2nd 1922 (Address) Curtis Bay, Balto. Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Middletown Balto Co. DATE OF BURIAL, May 4, 1922

20-UNDERTAKER Williams Cook Co ADDRESS 502 E North

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 2 - 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63946

CERTIFICATE OF DEATH.

90 D 63946

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 S Spring ST., 3 WARD)

2-FULL NAME Briget Hoffman

(a) RESIDENCE NO. 419 S Spring ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert Hoffman

6 DATE OF BIRTH (month, day, and year) July 20 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Wm Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Robert Hoffman
(Address) 419 S Spring St

15 MAY 2 - 1922 Robert Hoffman, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to May 1, 1922,

that I last saw h alive on May 1, 1922,

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) ... yrs. ... mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. Turnpenny M. D.

5-2, 1922 (Address) 1706 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loud Cem

DATE OF BURIAL May 3 1922

20 UNDERTAKER Wm A Wilson

ADDRESS 1713 Mc

B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given. Exact statement of occupation and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63947

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 63947

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Gough ST.: 3 WARD)

2-FULL NAME Rosina Ferrara

(a) RESIDENCE. NO. 1201 Gough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Natale Ferrara

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mary Monaco

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Natale Ferrara
(Address) 1201 Gough

15 Filed MAY 2 1922 Registrar

MAY 2 - 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1922, to April 24, 1922, that I last saw her alive on April 24, 1922, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) About 4 mos. ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin skin test - X-ray

(Signed) H. A. Meech, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	May 5 19 22
20 UNDERTAKER	ADDRESS
Hamill Mortuary	1 W Lan

I.—WHITE PERSONS should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63948

CERTIFICATE OF DEATH.

X 49 D 63948

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 St Mary St ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Booth

(a) RESIDENCE NO. 514 St Mary ST., Summit Point W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Summit Point Jefferson Co W Va

PARENTS

10 NAME OF FATHER Geo Berry Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Howe (Address) 514 St Mary St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1922, to April 30, 1922

that I last saw him alive on April 30, 1922

and that death occurred, on the date stated above, at 7. P. m.

The CAUSE OF DEATH* was as follows:

Gangrene + Blood Poision

Carcinoma of Throat

(duration) ..... yrs. 1 mos 17 ds.

CONTRIBUTORY (Secondary) Carcinoma of Throat

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Atlantic City. N.J.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr D W Kennard, M. D.

5-2 1922 (Address) 706 Euson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Summit Point Jefferson Co W Va

DATE OF BURIAL May 4

20 UNDERTAKER Samuel Hensley

ADDRESS 57 Baldwin

Burial Permit Clerk.

MAY 2 - 1922

N. B.—WRITE PLAINLY, with ink. All items must be filled in. AGE should be carefully supplied. AGE should be stated in years, months and days. Exact statement of occupation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-002

D 63949

Registered No. C.....

1-PLACE OF DEATH Brooklyn.

City of BALTIMORE: (No. Patapsco Ave. & 7th. St. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lawrence Cook Lorenzo Franco.

(Residence in Baltimore: No. 649 Patapsco Ave. Brooklyn St.; 2 yrs. ---- mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced, (Write the word.): Single.

6-DATE OF BIRTH: April 14th. 1920. (Month) (Day) 1..... (Year)

7-AGE: 2 yrs. -- mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of Industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER, Salvatore Franco.

11-BIRTHPLACE OF FATHER, (State or Country). Italy.

12-MAIDEN NAME OF MOTHER, Theresa Brocato.

13-BIRTHPLACE OF MOTHER, (State or Country). Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Franco. (father)

(Address) 649 Patapsco Ave. Brooklyn

15-Filed MAY 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1st. 1922. (Month) (Day) 192..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull & internal injuries. Struck by car of U. Ry & E. Co. Accidental Death.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto W. Bernhardt M. D. (Coroner)

May 2nd 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: 5/3 1922

20-UNDERTAKER: I. Frew McCully — ADDRESS: 130 E. Fort

N. B.—Every item of information should be carefully given, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 63950

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 63950

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S. 5th ST., 76 WARD)

2-FULL NAME Barbara Enders

(a) RESIDENCE NO. 116 S. 5th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Enders

6 DATE OF BIRTH (month, day, and year) Sept 17, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) New York

PARENTS

10 NAME OF FATHER Michael Schworer

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Not Known

14 Informant August Enders

(Address) 116 S. 5th St

15 FILED MAY 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/3/22, 19..... to 4/29/22, 19.....

that I last saw her alive on 4/29/22, 19.....

and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Pemphigus Acute

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY ~~Not~~ (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? -

(Signed) + R Bierman, M. D.

5/1, 19 (Address) 2919 E Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL May 4 1922

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63951

CERTIFICATE OF DEATH.

111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S. Collington Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Nelson

(a) RESIDENCE NO. 204 S. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Nelson

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER James Nelson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Kath. Friedel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Frances Nelson (Address) 204 S. Collington Ave

15 MAY 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 26, 1922, to Apr 30, 1922, that I last saw h[illegible] alive on Apr 30, 1922, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Penetrating ulcer of Pylorus stomach Fourth Degraded blood vessel

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Ulcer of Stomach

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Apr 30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Daniel L. Frazier M. D.

(Address) 332 S Paca St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL May 4 1922

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify AS ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant

Spec.—1-10-21—M&T—1500 Bks.

D 63952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63952

CERTIFICATE OF DEATH.

119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 442 N. Gay ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Wagner

(a) RESIDENCE NO. 442 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 76 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ the late Barbara Wagner

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigarmaker

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Kate Sorber

(Address) 442 N Gay St

15 MAY 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1922, to May 2, 1922, that I last saw him alive on 6:30 P.M. and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Focal Suppuration & General Debility (Senility)

(duration) Yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Pneumonia Bronchial

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

5/3/22 (Signed) Albert L. Levy M. D.

(Address) 1207 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 5th 1922

20 UNDERTAKER Henry Horch Son — ADDRESS 1801 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied

Spec. 6-2-19 H. P. Co. 1000 Blks.

D 63953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63953

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Townsend Ave., Brooklyn (St.) 35 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm F. Braunschafer

(a) RESIDENCE. No. Townsend Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Braunschafer

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Gen'l Industry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ferdinand Braunschafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Braunschafer
(Address) Same

15 Filed MAY 3 - 1922 19 ROBERT R. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1. 1918. to May 1st. 1922.
that I last saw h alive on May 1st 1922.
and that death occurred, on the date stated above, at 8 05 P m.

THE CAUSE OF DEATH* was as follows:

Diabetes Mellitus
Chronic Duty, Sclerosis Myocarditis
Arteriosclerosis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. H. Johnson, M. D.

, 19 (Address) Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	5/5/1922
20 UNDERTAKER	ADDRESS
Jno J Fahey & Sons	1310 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63954

REGISTERED NO. 129 D 63954

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1023 S. Third St. (ST.,) (26 WARD)

2-FULL NAME George B. Schaffer.

(a) RESIDENCE NO. 1023 S. Third St. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Schaffer.

6 DATE OF BIRTH (month, day, and year) Feb. 4—1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pensioner of

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. Army 0 P O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Schaffer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Laura Ruck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mabel Schaffer (Address) 1023 S. 3rd St.

15 Filed MAY 3 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to April 29, 1922, that I last saw h— alive on April 29, 1922, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A B Sellow M. D.

5/2, 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: May 3 1922

20 UNDERTAKER: Lilly & Zeile

ADDRESS: 403 N. Wolfe St.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Exact information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 63955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63955

CERTIFICATE OF DEATH.

1329

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3740 E. Baltimore ST., 76 WARD)

2-FULL NAME Conrad Mauler.

(a) RESIDENCE NO. 3740 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH CARE. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See CAUSE OF DEATH in plain terms, so that it may be properly classified. Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Mauler.

6 DATE OF BIRTH (month, day, and year) July 22 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Flour Inspector.

(b) General nature of industry, business, or establishment in which employed (or employer) Chamber of Commerce

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William A. Mauler

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Amelia Weitzel

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Laura Mauler (Address) 3740 E. Baltimore

15 FILED MAY 3 - 1922 ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1922

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1922, to May 1, 1922.

that I last saw h— alive on May 1, 1922

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic - Nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Owens M. D.

May 3 1922 (Address) 35 E. Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL May 4 1922

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63956

CERTIFICATE OF DEATH.

43 D 63956

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 S. Chester St. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathew G. Miller

(a) RESIDENCE NO. 223 S. Chester St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Miller.

6 DATE OF BIRTH (month, day, and year) Nov. 24 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	63	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 761

(b) General nature of Industry, business, or establishment in which employed (or employer) Policeman

(c) Name of employer E. D.

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER George Miller.

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret C. Smith.

13 BIRTHPLACE OF MOTHER (city or town) Ger.
(State or country)

14 Informant Grover Miller
(Address) 142 N. Luzerne St.

15 MAY 3 - 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to Apr 30, 1922, that I last saw h[illegible] alive on Apr 30, 1922, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. 4 mos - ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Specimen & Symptoms

(Signed) Samuel Hyman M. D.

, 19 (Address) 532 S Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL May 4 1922

ADDRESS 4038 W. Fay.

20 UNDERTAKER Lilly and Zeile

N. B.—WRITE PLAINLY, WITH INK. All items should be stated EXACTLY as supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Originated in submaxillary gland.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63957

161-081 63957

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Druid Hill Ave ST.. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Infant of Mr. & Mrs. Hezekiah Spencer

(a) RESIDENCE. No. 1222 Druid Hill Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 5-2-22

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Hezekiah Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lillie Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hezekiah Spencer
(Address) 1222 Druid Hill Ave

15 Filed 19 ROBERT R. KRAUTER Registrar

MAY 3 - 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/2 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 1922, to 5/2, 1922

that I last saw her alive on 5/2, 1922

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(about 6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. R. Lutts, M. D.

, 19 (Address) 2149 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 5-3 1922

UNDERTAKER: George H. Holland

ADDRESS: 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—[illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Bks.

Chanceaulme, V
24-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63958

CERTIFICATE OF DEATH.

REGISTERED NO. D 63958

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1210 E North Ave WARD 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L. Chanceaulme

(a) RESIDENCE NO. 1210 E North Ave ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 10 1839

7 AGE — Years: 82 Months: 3 Days: If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Martin Chanceaulme

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Sarah Hanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Curtis A. Curtis (Address) 1210 E North Ave

15 Filed MAY 3 19-1922 ROBERT R. KRAUSE Registrar

Gilroy 622 W. North Ave Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1922, to May 2, 1922, that I last saw h[illegible] alive on May 1, 1922 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds. (Primary)

CONTRIBUTORY (Secondary) Artero Sclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W J Gilroy M. D.

5-19 22 (Address) 622 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL May 4 1922

UNDERTAKER: William Cook ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION

D 63959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63959

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. St Joseph's Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Franklin Pierce Wheeler

(Residence in Baltimore: No. 3125 E. Monument St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (~~Write the word.~~) Married

6-DATE OF BIRTH, Oct 8 1857 (Month) (Day) (Year)

7-AGE, 65 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Henry Wheeler

11-BIRTHPLACE OF FATHER, (State or Country), Balt'r

12-MAIDEN NAME OF MOTHER, Mary Wheeler

13-BIRTHPLACE OF MOTHER, (State or Country). Balt'r

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Wheeler

(Address) 3125 E. Monument

15- MAY 3 - 1922 ROBERT B. KRAUTER, Burial Permit Clerk. (Burial Permit Officer.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1 192.2 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stunned by pistol

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

5-3 192 (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, May 4 1922

20-UNDERTAKER, H. McCorkle — ADDRESS [illegible] May

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 63960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63960

164

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 N. Calhoun ST. 19 WARD)

2-FULL NAME Mary Kelly

(a) RESIDENCE. NO. 432 N. Calhoun ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of James Kelly

6 DATE OF BIRTH (month, day, and year) Oct. 10

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McNulty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) James Kelly 432 N. Calhoun St

15 Filed MAY 3 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Apl. 20. 1922, to Apl 29. 1922, that I last saw he alive on Apl. 29 1922, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) ... yrs. ... mos. 9. ds.

CONTRIBUTORY (Secondary) old age.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert C Blake, M. D.

. 19 (Address) 1014 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	May 4 1922
20 UNDERTAKER Margaret J. Flynn	ADDRESS 1412 Light St.

N. B.—WRITE PLAINLY. All questions should be carefully answered and information supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Rybicki) ✓ 100,002

D 63961

CERTIFICATE OF DEATH.

D 63961

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Washington St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Rabitski

(Residence in Baltimore: No. 602 S. Washington St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 27 (Day), 1921 (Year)

7-AGE, ...yrs. 6 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): Off

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Steven Rybicki

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sophia Labedzinski

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Steven Rybicki

(Address) 602 S. Washington St.

15- MAY 3 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 24 1922, to May 2 1922, that I saw him alive on May 2 1922, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H. Kalberer M. D.

May 2, 1922 (Address) 1709 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, May 3, 1922

20-UNDERTAKER John M. Weber — ADDRESS 1803 Bank St.

WRITE PLAINLY, with ink. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is very CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 63962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63962

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2203 Dougl St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Devine

(Residence in Baltimore: No. 2203 Dougl St. 44 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Dec. 19 — 1876
(Month) (Day) (Year)

7-AGE: 45 yrs. 4 mos. ds.
If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country): Ind.

PARENTS.

10-NAME OF FATHER: Patrick Devine

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Hannah Kane

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Devine

(Address) 2203 Dougl St

15- FILED MAY 3 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May 2 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma
Pelvis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner) 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Farmington Ave DATE OF BURIAL: 5-4- 1922

20-UNDERTAKER: J. J. Moran ADDRESS 3000 E. Baltimore

N. B.—Every item of information should be properly answered, so that it may be plain terms, so that it may be plainly stated. CAUSE OF DEATH in plain terms, so that it may be plainly stated. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63963 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63963

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 E Preston ST., 19 WARD)

2-FULL NAME Annie Gately

(a) RESIDENCE NO. 822 E. Preston ST., 9 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNUSUAL CARE. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael J. Gately

6 DATE OF BIRTH (month, day, and year): Jan 17-1854

7 AGE: Years 68 Months 1 Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Michael J. Gately 822 E. Preston St.

15 Filed MAY 3 -1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1921, to May 1, 1922, that I last saw him alive on April 30, 1922 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Carcenoma of liver

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

6' 2, 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: May 4 1922

UNDERTAKER: J. J. Moran

ADDRESS: 3000 E Baltimore St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63964

CERTIFICATE OF DEATH.

REGISTERED NO. C 1600 D 63964

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Josephs Hosp. St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madie P. Parker

(Residence in Baltimore: No. 1355 Whatcoat St. St.; ..... yrs., Life mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 14, 1908
(Month) (Day) (Year)

7-AGE, 14 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto - Md.

PARENTS.

10-NAME OF FATHER, George Parker

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Parker

(Address) 1355 Whatcoat St.

15-

Filed MAY 3 - 1922 J. Elliott Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 30 1922, to May 1 1922, that I saw her alive on May 1 1922, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Streptococcic pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) F. C. Manges M. D.

May 1, 1922 (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cemetery — DATE OF BURIAL, May 4, 1922

20-UNDERTAKER Laurence H. Dennis — ADDRESS 1303 Druid Hill Ave.

N.B.—Every item of information should be carefully supplied. AGE should be classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly

Remarks

Broncho.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63965

CERTIFICATE OF DEATH.

REGISTERED NO. 100 D 63965

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1115 Whitecot ST.: 16 WARD)

2-FULL NAME Carroll E. Gibson

(a) RESIDENCE. NO. 1115 Whitecot ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY with pen and ink. AGE should be stated EXACTLY. If unknown, information should be carefully supplied. AGE should be carefully classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 13 - 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Howard W. Gibson
11 BIRTHPLACE OF FATHER (city or town) Bilbo. Ltf
(State or country) Md.
12 MAIDEN NAME OF MOTHER Helen Simms
13 BIRTHPLACE OF MOTHER (city or town) Cross Cumpke Co Miss
(State or country)

14 Informant Louise Gibson
(Address)

15 Filed MAY 3 1922 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 5 1922, to Apr. 30 1922, that I last saw him alive on Apr. 29 1922, and that death occurred, on the date stated above, at 7-10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) - yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? done
(Signed) Chas. L. McCarthy M. D.
, 19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL N. W. Auburn Cemetery — DATE OF BURIAL May 4 1922

20 UNDERTAKER James A. Dennis — ADDRESS 1303 Greenmount

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 63966

D 63966

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

" " " ST., 7 WARD)

CITY OF BALTIMORE: (No. .....

2-FULL NAME Eva Bunk.

(a) RESIDENCE NO. 826 S. Milton Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. like mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2. 1922

7 AGE — Years — Months — Days If LESS than 1 day, 8 hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) (Boy)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Joseph F. Bunk

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Fox

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Records.

15 MAY 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1922, to May 2nd, 1922, that I last saw h alive on May 2nd, 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Birth weight 2 lbs. 1 z.)

8 hours. —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) H. H. Mesch, M. D.

May 3, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem'y — DATE OF BURIAL May 3 1922

20 UNDERTAKER Stephen J. Fialkowski — ADDRESS 1000 Fleming Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling out information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling out information should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63967 — 179D 63967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Day Jr.

(a) RESIDENCE NO. 321 N. Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should fill in all items. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma A. Day

6 DATE OF BIRTH (month, day, and year) Oct 16, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman B+O R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Nicholas Day Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Fowler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Emma A. Day
(Address) 321 N. Woodyear St

15 MAY 3 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2 - 1922

17 I HEREBY CERTIFY, That I attended deceased from June - 6 - , 1922, to May - 2 , 1922, that I last saw him alive on May - 2 , 1922, and that death occurred, on the date stated above, at 930 A m.

The CAUSE OF DEATH* was as follows:

Emphysema - following unresolved Pneumonia

Chronic Serous Pleurisy

Chronic Interstitial Nephritis.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Chronic Conn of Convulsions

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Newton D. Parr, M. D.

5/2, 1922 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 5 1922
20 UNDERTAKER	ADDRESS
Harry H. Witzke	521 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63968

D 63968

131

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Welzant

(a) RESIDENCE. NO. 317 S. wolfe st. ST., WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Welzant

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

063

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Roman Welzant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frances Martineksi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records M.T.H.

15 Filed MAY 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1922, to May 2, 1922, that I last saw him alive on May 2, 1922, and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglacar M. D

5-2-22 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery.	May 4. 1922
20 UNDERTAKER	ADDRESS
M J. Sadowski.	405 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63969 ✓ X46 D 63969

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Harlem Ave. ST., 16 WARD)

2-FULL NAME Lovell Mildred Smith

(a) RESIDENCE NO. 1912 Harlem Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS RECORD MUST BE FILLED OUT EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry C. Smith

6 DATE OF BIRTH (month, day, and year) Mch. 6" 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Russell Feigin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Henrietta Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Harry C. Smith (Address) 1912 Harlem Ave.

15 MAY 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1922 to May 1, 1922 that I last saw h-r alive on May 1, 1922 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Metastasis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Catonsville yes Date of Sept 26-1919

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Labratory findings X Ray

(Signed) Paul Brooks M. D.

May 3 1922 (Address) 1637 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL May 3" 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1603 N. Balto

D 63970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63970

CERTIFICATE OF DEATH.

REGISTERED No. C 197

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 130 Jo Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eddie Flores

(Residence in Baltimore: No. (Camp meade) St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word) Single

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 32 Years. yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Corps Medical

9-BIRTHPLACE, (State or Country), San Salvador Central America

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. R. Insley

(Address) 2938 E. Balto, Md

15- Filed MAY 3 - 1922, 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by Gun Shot (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. Kirk Insley (Coroner.) M. D.

5-8, 1922 (Address) 4 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Camp Mead — DATE OF BURIAL, ..., 19....

20-UNDERTAKER W J Hartley — ADDRESS 815 R Tworkinet

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 63971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63971

CERTIFICATE OF DEATH.

161-081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Orem ST. 13 WARD)

2-FULL NAME Alice Weissing

(a) RESIDENCE NO. 2235 Orem ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): April 16-1922

7 AGE: Years | Months | Days: 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work: ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Weissing Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Katherine Schmick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Henry Weissing Jr (Address) 2235 Orem St

15 MAY 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1922, to May 3, 1922, that I last saw h[illegible] alive on May 3, 1922, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? premature birth

(Signed) Dannie Miller, M. D.

19 (Address) 1506 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: May 3 1922

20 UNDERTAKER: J Ullrich — ADDRESS: 2018 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

(See affadavit over) ✓

D 63972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63972

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 Druid Hill ave ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wilson

(a) RESIDENCE NO. 1017 Druid Hill ave ST., WARD Oakland Calif

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. Wilson

6 DATE OF BIRTH (month, day, and year): not stated

7 AGE: Years: about 55 | Months: | Days: | If LESS than 1 day, ...hrs. or ....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Ephrum Randall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Celia A. Guest

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs E. P. Calloway

15 Filed ....., 19..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/29/1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 22, 1922, to Apr 29, 1922, that I last saw h[illegible] alive on Apr 29, 1922, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Uremia (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Phoenic Interstitial Nephritis (duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tomprins M. D.

19 (Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland, Cal.

DATE OF BURIAL: May 7 1922

20 UNDERTAKER: Jno. M. Johnson

ADDRESS: 234 Eutaw St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY. PHYSICIANS should state EXACTLY, where DISEASE existed. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- that it may be CAUSE OF DEATH in plain terms, so TION is very important. See instructions on back of certificate.

V-8 - 1922

State of Arizona,)
County of Santa Cruz,)SS

Mary I. Firmes being duly sworn, deposes and says: that she is the daughter of the late Ann Elizabeth Wilson, who died on the 29th day of April, 1922, at the residence of Mrs. Elizabeth Calloway, 1017 Druid Hill Avenue, Baltimore, Maryland; that at the death of the late Ann Elizabeth Wilson, the age given the undertaker, Mr. John Johnson, 1234 Etting Street, Baltimore, Maryland, by Mrs. Elizabeth Calloway was seventy-five years. Affiant further states that the age given by Mrs. Elizabeth Calloway was errenous; that affiant has consulted the family bible and found that the correct age of the said Ann Elizabeth Wilson, deceased, at the time of her death was fifty-five years. Affiant also states that the full name of the said Ann Elizabeth Wilson, deceased, was not given to the said John Johnson, by the said Elizabeth Calloway, only Elizabeth Wilson was given, further affiant says not.

Mary I. Firmes.

Subscribed and sworn to before me this 27th day of July, 1922.

Notary Public in and for the County of Santa Cruz.

Camp Stephen D. Little,
Nogales, Arizona, July 27, 1922.

City Health Department,
Baltimore, Md.

Sir:-

It is requested that I be furnished at your earliest practical convenience a certified copy of the death certificate of the late Mrs. Ann Elizabeth Wilson, who died on April 29th, 1922, at 1017 Druid Hill Avenue, Baltimore, Maryland, whose age at time of death was fifty-five years.

The name and age given of the deceased by Mrs. Elizabeth Calloway, was, "Elizabeth Wilson, age 75", both being incorrect. As I arrived in Baltimore June 2nd and left with the remains for California, the next evening, June 3rd, 1922, and did not see the death certificate until it was handed to me just before I boarded the train, I did not have time to have the records corrected. I am enclosing an affidavit covering the errors, together with fifty cents for a certified copy of the corrected death certificate, which, when completed, please return to me at Camp Stephen D. Little, Nogales, Arizona.

Respectfully,

Mary I. Firmes.

(Mrs.) Mary I. Firmes.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63973

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Mercy Hospital ST.: 7 WARD)

2-FULL NAME Wm. Smith

(a) RESIDENCE. NO. 909 E. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 38 (?) Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harriet —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mercy Hospital Records

(Address) Robert Y. Lattimore,

15 MAY 3 1922 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20 1922 to Apr. 29 1922

that I last saw him alive on Apr. 29 1922

and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency 16 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no Signs & Symptoms

What test confirmed diagnosis? Physical

(Signed) John J Erwin, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: 19

20 UNDERTAKER

ADDRESS MAY 3 1922

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should give information exactly. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5/4/8

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63974

D 63974

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST.: ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Hoe. Collins

(a) RESIDENCE. No. 13 Francis St. Annapolis WARD. Annapolis Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annabel Timms

6 DATE OF BIRTH (month, day, and year) May 4- 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer U.S. Naval academy

9 BIRTHPLACE (city or town) (State or country) Bucktown Md.

PARENTS

10 NAME OF FATHER J R D Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) East New market Md.

12 MAIDEN NAME OF MOTHER Elizabeth J Mercer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bucktown Md.

14 Informant (Address) J R D Collins Cambridge Md.

15 Filed MAY 8 - 1922 19 Robert V. Latrobe, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1922, to May 3, 1922, that I last saw him alive on May 3, 1922, and that death occurred, on the date stated above, at 12 & 0 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Plastic operation of nose

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 25, 22

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) W W Jones, M. D.

5/3, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md.	May 3 1922
20 UNDERTAKER Jas. T. Taylor Sons	ADDRESS Annapolis Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63975

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 63975

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH: 2908 Pennington Ave. (Pennington Ave.) 161

CITY OF BALTIMORE (No. 2908 ST.: Pennington Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Ida L. Lee

(Residence in Baltimore: No. 2908 Pennington Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fe.

4-COLOR OR RACE: C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, April 26, 1922 (Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE. (State or Country): 2908 Pennington Ave Baltimore City

PARENTS.

10-NAME OF FATHER: John Lee

11-BIRTHPLACE OF FATHER (State or Country): Port Deposit Md

12-MAIDEN NAME OF MOTHER: Ida Hooker

13-BIRTHPLACE OF MOTHER (State or Country): Washington D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lee

(Address) 2908 Pennington Ave

15-

Filed May 3, 1922 Robert F. Leslie, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May 3, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) did find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia Bilateral

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

May 3, 1922 (Address) 7632 Rockdale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER

ADDRESS 3-1922

WRITE PLAINLY. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 3 - 1922 Burial Permit Clerk

(Le Duce)

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 63976

CERTIFICATE OF DEATH

100,001

D 63976

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 166 W. Fort ave, ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Myers LeDuce

(Residence in Baltimore: No. 166 W. Fort ave St.; ..... yrs. 7 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Feb (Month) 19 (Day) 1914 (Year)

7-AGE: ..... yrs. 7 mos. 12 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): 166 W. Fort ave Baltimore Md

PARENTS

10-NAME OF FATHER: Louis LeDuce

11-BIRTHPLACE OF FATHER (State or country): Maine

12-MAIDEN NAME OF MOTHER: Carrie Vogel

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie Le Duce

(Address) 166 W. Fort ave.

15- Robert F. Kerrigan

Filed ..... 191 ..... REGISTRAR

MAY 8 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 2 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 30, 1922, to, May 2 1922, that I saw him alive on May 1 1922, and that death occurred, on the date stated above, at 1.10 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs ..... mos 3 ds.

Contributory (SECONDARY) Contusion

(Duration) ..... yrs ..... mos ..... ds.

(Signed) O. Evans M. D.

May 2 1922 [Address] 1215 Hanover

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: May 4, 1922

20-UNDERTAKER: O'Neill E. Evans

ADDRESS: 1428 S. Hanover St

Jones

WRITE PLAINLY, with pen or indelible pencil.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 63977

90 D 63977

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1388 West North Ave ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bernard A Behrend

(Residence in Baltimore: No. 1388 West North ave St.: 42 yrs. 11 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	Single

6 DATE OF BIRTH May (Month) 25 (Day), 1879 (Year)

7 AGE 42 yrs. 11 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work clerk
(b) General nature of industry, business, or establishment in which employed (or employer) ffg

9 BIRTHPLACE (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Aaron Behrend

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Jeanette Cohn

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Flora Pollack

(Address) 1112 Eutaw St

15 Filed ..... 191 Robert F. Carrion, Burial Permit Clerk. REGISTRAR

MAY 5 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 3 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1921 to May 3rd 1922

that I saw him alive on May 3rd 1922

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

3 (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Flora Pollack M. D.

May 3rd 1922 (Address) 1112 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hebrew Friendship — DATE OF BURIAL May 5 1922

20 UNDERTAKER J. Ahrens & Co. — ADDRESS 1611 Madison

Spec.—1-10-21—M&T—1500 Bks.

D 63978

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 101

D 63978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital 101

CITY OF BALTIMORE: (No. ..... ST., 70 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Janie Anne Wheeler

(a) RESIDENCE NO. 1826 Mulberry ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 6 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct. 26 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Sylvester A.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co.

12 MAIDEN NAME OF MOTHER Catherine Wittig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Father

(Address) 1826 W Mulberry St.

15 Filed Robert P. Harrison, Registrar

MAY 3 - 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/1922

17

I HEREBY CERTIFY, That I attended deceased from 4/28/, 1922, to 5/2/, 1922.

that I last saw h[illegible] alive on 5/2/22, 19

and that death occurred, on the date stated above, at 4.10 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Peritonitis (Pneumococcus)

..... (duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/28/22

Was there an autopsy? No obn

What test confirmed diagnosis?

(Signed) H V Harper M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 5/2 1922

20 UNDERTAKER Jones & Toulson

ADDRESS 12-14 N Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be properly supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ruptured Appendix

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63979

CERTIFICATE OF DEATH.

D 63979

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 Walbrook ave ST. 15 WARD)

2-FULL NAME Antonino Maria

(a) RESIDENCE. No. 2233 Walbrook ave ST.

WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucia Alagna

6 DATE OF BIRTH (month, day, and year) July - 5. 1862

7 AGE 59 Years 9 Months 27 Days | If LESS than 1 day, hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER G. Battista Maria

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Maria Ligari

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Giovan Battista Maria (Address) 2233 Walbrook ave

15 Filed Robert P. Lattimer, Registrar

MAY 3 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 - 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1922 to May 2, 1922

that I last saw h.im alive on May 1, 1922

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Don't Know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes'

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W B Gonal, M. D.

5/2, 1922 (Address) 111 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 5/5/ 19

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

N. B.—WHITE PLANET, MULATTO STAR. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63980

CERTIFICATE OF DEATH.

46 D 63980

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Toy

(a) RESIDENCE. NO. 914 Warner St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Naddie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records.
(Address) Municipal Hospital.

15 MAY 4 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to May 2, 1922, that I last saw her alive on May 2, 1922, and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows: Carcinoma of uterus

uremia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) hypostatic pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. S. Hobbs, M. D.

5/3/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 5 19
20 UNDERTAKER	ADDRESS
John H. Tradin	142 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63981

CERTIFICATE OF DEATH.

43 D 63981

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 E. Fort Ave. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav A. Meyer

(a) RESIDENCE. No. 1106 E. Fort Ave. St., Ward.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Augusta B. Meyer

6 DATE OF BIRTH (month, day, and year) Jan. 31 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Wm. Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Broesicker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Augusta B. Meyer 1106 E. Fort Ave.

15 [illegible] MAY 4 - 1922

ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 1921 to May 1 1922

that I last saw h~~im~~ alive on May 1 1922

and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue.

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes Date of March 1921.

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam.

(Signed) Sidney H. Streett, M. D.

5/2 1922 (Address) 408 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: 5/4 1922

20 UNDERTAKER: I. Few McCully

ADDRESS: 130 E. Fort

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 63982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63982

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 W. Barney St. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles I. Timanus

(a) RESIDENCE. NO. 9 W. Barney St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in giving CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	1	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob H. Timanus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mr. Jacob Timanus (father) 9 W. Barney St.

15 Filed MAY 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1922, to May 3, 1922, that I last saw him alive on May 3, 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions and pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm. E. Stigler, M. D.

5/3 1922 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem

DATE OF BURIAL 5/7 1922

20 UNDERTAKER D. Finn McCully

ADDRESS 130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63983 — 129 D 63983

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.: 7 WARD)

2-FULL NAME David Etelson

(a) RESIDENCE. NO. 1601 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. V mos. V ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gutmann

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	V	V	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work -

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Etelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Samuels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Etelson (Address) 1601 Monumental St

15 Filed MAY 4 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922, to May 4, 1922.

that I last saw him alive on May 4, 1922.

and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

~~1a~~ Uraemia

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Moses Gellman, M. D.

5/4, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levering Southern and

DATE OF BURIAL May 4 1922

20 UNDERTAKER Max Levinson

ADDRESS 1112 E Balto St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63984

CERTIFICATE OF DEATH.

90D 63984

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Parrish ST., 16 WARD)

2-FULL NAME Robert Tyler

(a) RESIDENCE NO. 1017 Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE... PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Tyler

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
35 Bet 30 & 40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER John Tyler

11 BIRTHPLACE OF FATHER (city or town) HowardCo (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Tyler

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mary Tyler

(Address) 302 N Stricker St

15 MAY 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1922, to May 2, 1922, that I last saw h[illegible] alive on May 2, 1922, and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Chronic)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) E William Frey, M. D.

5/2, 1922 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 4 1922
20 UNDERTAKER	ADDRESS
Edward Purgold	1463 Carey St

D 63985 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 63985

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 Hanover St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Bush. 50 yrs. mos. ds.)

(Residence in Baltimore: No. 911 Hanover St. St.;

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. April 4th. 1850. (Month) (Day) 1..... (Year)

7-AGE. 72 yrs. mos. 27 ds. If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker.
(b) General nature of industry, business, or establishment in which employed (or employer): 884

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. John A. Bush.

11-BIRTHPLACE OF FATHER. (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Mary Booker.

13-BIRTHPLACE OF MOTHER. (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliza Bush. (wife).

(Address) 911 Hanover St.

15- MAY 4 - 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1st. 1922. (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

May 2nd. 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Cemetery	May 4 1922
20-UNDERTAKER. John F. Denny	ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

63986

CERTIFICATE OF DEATH.

47 D 63986

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 W Mulberry ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Dickerson

(a) RESIDENCE. NO. 739 W Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Dickerson

6 DATE OF BIRTH (month, day, and year) May 7. 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER McHenry Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Moreland Co Va.

12 MAIDEN NAME OF MOTHER Emmeline Hewson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Moreland Co Va

14 Informant James M Pierce.
(Address) 739 Mulberry St

15 Filed MAY 4 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from February 10, 1922, to May 3, 1922

that I last saw her alive on May 2, 1922

and that death occurred, on the date stated above, at 11.40 P, m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast Rt.
(duration) yrs. 3 ? mos. ds.

CONTRIBUTORY (Secondary) None -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? New York.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical. X Ray.

(Signed) William H Wright M. D.

May 3, 1922 (Address) 120 9 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetary	May 4 1922

20 UNDERTAKER Clement Hall 909 Fulton St ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 63987

D 63987

CERTIFICATE OF DEATH. Mt Washington

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Cor. Pilmico & Ridgely Roads ST., 74 WARD)

2-FULL NAME William A. Wilson

(a) RESIDENCE NO. Cor. Pilmico & Ridgely Roads ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie M Wilson

6 DATE OF BIRTH (month, day, and year) Dec 9 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Superintendent 086
(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mills
(c) Name of employer Laurel

9 BIRTHPLACE (city or town) Laurel
(State or country) Maryland

PARENTS
10 NAME OF FATHER George W. Wilson
11 BIRTHPLACE OF FATHER (city or town) Laurel
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Rachel M. Penn
13 BIRTHPLACE OF MOTHER (city or town) Montgomery Co Md
(State or country)

14 Informant Mrs Annie M. Wilson
(Address) Pilmico & Ridgely Roads

15 Filed MAY 4 - 1922 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1922, to May 2, 1922,
that I last saw him alive on May 2, 1922,
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH was as follows:
Apoplexy

(duration) yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) S. R. Wantz M. D.
May 3 1922 (Address) 865 N 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL May 5 1922
20 UNDERTAKER A. S. Marshall — ADDRESS 3539 Falls Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Schewa)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63988

D 63988

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Schewa

(Residence in Baltimore: No. Belair Road Opp. Holy Redeemer Cemetery St. 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ..., 1845
(Month) (Day) (Year)

7-AGE, 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Florist
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Gordlei.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Joseph Douglas

(Address) 2049 Gorsuch St.

15- MAY 4 — 1922 191.. Burial Permit ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 28 1922, to May 2 1922; that I saw h.C.R. alive on May 2 1922; and that death occurred, on the date stated above, at 1 0 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. C. Marino M. D.

May 2, 1922 (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, May 5th, 1922

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Remline ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63989

CERTIFICATE OF DEATH.

4 179 D 63989

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Remline

(a) RESIDENCE. NO. Mercy Hospital ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 6, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Remline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mercy Hospital Records

15 Filed . 19 ROBERT B. KRAUTER, Registrar

MAY 4 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 22

17 I HEREBY CERTIFY, That I attended deceased from Apr 29 . 1922 to May 3 . 1922 that I last saw h im alive on May 3 . 1922 and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Uremia and Hypostatic Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs Symptoms

(Signed) John J Ervin, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL May 6 1922

20 UNDERTAKER Lilly & Sons

ADDRESS 408 S. Wolfe St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis
No other abnormal
condition. Has been
at hospt. 3 yrs. to
Dr's knowledge

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63990

CERTIFICATE OF DEATH.

D 63990

31

D 63990

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C.F. Koshland

(a) RESIDENCE NO. 134 W. Baltimore, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 866

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Koshland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Vandellan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) Municipal Hospital

15 FILED MAY 4 - 1922 ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922. to April 30, 1922.

that I last saw him alive on April 30, 1922.

and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Neal M. D.

5/1/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery DATE OF BURIAL May 4 1922

20 UNDERTAKER J. & M. OWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 63991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63991

CERTIFICATE OF DEATH

118-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Fowbert & Greene ST. 21 WARD)

2-FULL NAME Catharine Scheidt

(a) RESIDENCE. NO. 902 S. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE August Scheidt

6 DATE OF BIRTH (month, day, and year) Sept 30 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	yrs 7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Siemmers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Mowes

13 BIRTHPLACE OF MOTHER (rity or town) (State or country) Germany

14 Informant (Address) August Scheidt 902 S. Paca St.

15 Filed MAY 4 - 1922 . 19 ROBERT A. KOHLHEPP, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-22 19

17 I HEREBY CERTIFY, That I attended deceased from 4-24 , 1922 to 5-2 , 1922 that I last saw her alive on 5-2-22, 19 and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-24-22

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) B. Peyton M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL May 5 1922

20 UNDERTAKER Wm Frickhinger Sons

ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 63992 (1-PLACE OF DEATH)

100,001

D 63992
REGISTERED NO.

CITY OF BALTIMORE: (No. 1815 Guilford Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Louise Walker

(a) RESIDENCE. NO. 1815 Guilford Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER W. J. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York City

12 MAIDEN NAME OF MOTHER Jane Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Walker
(Address) 1815 Guilford Ave

15 Filed ..., 19 ... Registrar

MAY 4 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1922, to May 3, 1922, that I last saw h.r alive on May 3, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: over

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Philibert Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	May 5 1922
20 UNDERTAKER	ADDRESS
E. A. Wiedefeld & Son	501 E 22 St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 63993 HEALTH DEPARTMENT—CITY OF BALTIMORE D 63993

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 E Lanvale ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Cunningham

(a) RESIDENCE. No. 423 E. Lanvale St.; WARD. 12th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 79 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Cunningham

6 DATE OF BIRTH (month, day, and year) April 14 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia

PARENTS

10 NAME OF FATHER John Heubock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Cath. Zettman

13 BIRTHPLACE OF MOTHER, (city or town) (State or country) Philadelphia

14 Informant (Address) Mrs Heubock 423 E Lanvale St

15 Filed MAY 4 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2d 1922

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1922, to May 2d, 1922, that I last saw h&x alive on May 2d, 1922, and that death occurred, on the date stated above, at 9.15 p. m.

The CAUSE OF DEATH* was as follows:

Cyemia.

(Bed sores on feet (?) origin

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastatic abscesses.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 122 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	May 5 1922
20 UNDERTAKER E. A. Wiedefeld	ADDRESS 501 E 23d St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

63994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

001

100 D 63994

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Thames ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Myers

(a) RESIDENCE. NO. 1128 Thames ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balti
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Molli Myers

13 BIRTHPLACE OF MOTHER (city or town) Balti-
(State or country) Md

14 Informant Marian Myers
(Address) 1128 Thames St.

15 Filed MAY 4 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1922, to May 2, 1922, that I last saw him alive on May 2, 1922, and that death occurred, on the date stated above, at 3-50 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

5-4, 1922 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	May 4 1922
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D63995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

D 63995

REGISTERED NO.....

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.: 6 WARD)

2-FULL NAME Mrs. Sam Rockkind

(a) RESIDENCE. No. 243 N Patterson Park Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer & Plaster

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Bernard Rockkind

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Susan Rockkind

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address) 1439 E Baltimore St

15 Filed MAY 4 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-2, 1922, to 5-4-, 1922

that I last saw him alive on 5-4-, 1922

and that death occurred, on the date stated above, at 7.30 PM

The CAUSE OF DEATH* was as follows:

Post Operative Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction due to adhesions

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-2-22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

5/4, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrem Mt Carmel Cem — DATE OF BURIAL: 5/4 1922

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

D 63996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 63996

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1523 N. Baltst ST., (or) 3 WARD)

2-FULL NAME Rosa Seidel

(a) RESIDENCE NO. 1523 N Baltst ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Seidel

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 65 Months Days

If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltst

15 Filed MAY 4 - 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3 1922

17

I HEREBY CERTIFY, That I attended deceased from April 20th, 1922, to May 3d, 1922, that I last saw her alive on May 3rd, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation & Angina pectoris

(duration) ..... yrs. mos 1 X ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What tests confirmed diagnosis? .....

(Signed) M Shedecker M. D.

, 19 (Address) 2328 Mud ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen circle cem — DATE OF BURIAL: 5/4 1922

20 UNDERTAKER: Jack Lewis 1439 E Baltst — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 63997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63997

CERTIFICATE OF DEATH.

X 25 1922

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Annapolis Ave. Mt. Winans. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer H. Barditch.

(Residence in Baltimore: No. 29 Annapolis Ave. Mt. Winans St.; yrs. 5 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-Single, Married, Widowed or Divorced, (Write the word.) Single.

6-DATE OF BIRTH. November 28th. 1906. (Month) (Day) (Year)

7-AGE. 15 yrs. 5 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School boy.
(b) General nature of industry, business, or establishment in which employed (or employer). ...

9-BIRTHPLACE, (State or Country). Russia.

PARENTS.

10-NAME OF FATHER. Isidore Barditch.

11-BIRTHPLACE OF FATHER, (State or Country). Russia.

12-MAIDEN NAME OF MOTHER. Bessie Tatelbaum.

13-BIRTHPLACE OF MOTHER, (State or Country). Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Tatelbaum. (uncle)

(Address) 60 Annapolis Ave. Mt. Winans.

15-

Filed MAY 4 - 1922 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage due to fracture of the skull, Knocked down & run over by an Automobile Homicide (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

May 3rd 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rit Carmel — DATE OF BURIAL, 5/4 1922

20-UNDERTAKER, Jack Lewis — ADDRESS 1439 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63998

CERTIFICATE OF DEATH.

D 63998

REGISTERED NO. 38

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. ..... ST., 19 WARD)

2-FULL NAME Arthur McCormick

(a) RESIDENCE NO. 1614 W. Lexington ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Do
(State or country)

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) Do.
(State or country)

14 Informant Bay View Hospital
(Address) Balto. Md.

15 Filed MAY 4 - 1922 J. H. Wilms Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1. 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20. 1922 to May 1. 1922

that I last saw him alive on May 1. 1922

and that death occurred, on the date stated above, at 1255 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical

(Signed) N. Goldsmith Ludwig M. D.

5/1, 1922 (Address) Bay View Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL May 4 1922

20 UNDERTAKER Samuel Bleasby

ADDRESS 528 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 63999

CERTIFICATE OF DEATH.

D 63999

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 584 Presbrust St W. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Thomas

(Residence in Baltimore: No. 584 N Preston St.; ..... yrs., life mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, ... (Month) ..... (Day), 1864 (Year)

7-AGE, 58 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Abraham Brown

11-BIRTHPLACE OF FATHER (State or Country), Prince Co Md

12-MAIDEN NAME OF MOTHER Margaret Hagelton

13-BIRTHPLACE OF MOTHER (State or Country), — Md —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Thomas

(Address) 584 Preston St

15-

Filed MAY 4 - 1922

J. Wilson Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 2 (Day), 1922 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 15 1922, to May 2 1922, that I saw h[illegible] alive on May 1st 1922, and that death occurred, on the date stated above, at 2.40 PM.

The CAUSE OF DEATH* was as follows:

(1) Intestinal Obstruction

(Duration) ..... yrs. One mos. 7 ds.

CONTRIBUTORY (Secondary) Cancer

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Gustav Lohmann M. D.

....., 191... (Address) 1306 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem DATE OF BURIAL, May 5, 1922

20-UNDERTAKER Samuel Handley ADDRESS [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

Turner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64000

CERTIFICATE OF DEATH.

D 64000

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 Pierce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Turner

(Residence in Baltimore: No. 746 Pierce St. 10 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1880
(Month) (Day) (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... private family

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Major Hughlin

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Hooten

(Address) Norfolk Va (daughter)

15- Filed MAY 4 - 1922, 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1922, to May 2 1922, that I saw h.. alive on May 2 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Valvular Disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William E. Burlew M. D.

May 3, 1922 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, McAuburn Cem. DATE OF BURIAL, May 4, 1922

20-UNDERTAKER Samuel Hendry ADDRESS 1395 Bridge

Spec.—1-10-21—M&T—1500 Bks.

D 64001

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

D 64001

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Whittier Ave. ST., 13 WARD)

2-FULL NAME Max Swimmer,

(a) RESIDENCE NO. 2309 Whittier Ave., ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Swimmer,

6 DATE OF BIRTH (month, day, and year) Oct. 12th. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dyer & Cleaning

(b) General nature of industry, business, or establishment in which employed (or employer) 071

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Kellman Swimmer,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Louis Swimmer.
(Address) 2309 Whittier Ave.

15 Filed MAY 12 1922 H. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd. 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1921, to May 3 1922, that I last saw h.. alive on May 2 1922, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukaemia

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Blood -

(Signed) Chas J Bloke, M. D.

May 3. 1922 (Address) 20 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew

DATE OF BURIAL May 5. th. 19

ADDRESS

20 UNDERTAKER David Sondheim 113 W. Mt. Re... av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 64002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Veterans' Hospital #56

CITY OF BALTIMORE: (No. Fort Mc Henry Md. ST., 38 WARD) 11

2-FULL NAME James White.

(a) RESIDENCE No. 311 W. Madison St, Balto, Md. US. Veterans' Hospital #56 ST., 38 WARD Fort McHenry Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25 yrs.	-	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Forester. 086

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) India.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Records. Fort McHenry (Address) Maryland.

Filed ... 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1922, to May 2, 1922.

that I last saw him alive on May 2, 1922,

and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary Tuberculosis

---- (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ----

--- (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam & Clinic data.

(Signed) M. L. Foster M. D.

Surgeon US. P.H.S.

5/2, 1922 (Address) US.V. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 4 1922

20 UNDERTAKER L. Thompson Bro — ADDRESS 1127 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 141 D 64003

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Franklin Sq. Hospital ST., 19 WARD)

2-FULL NAME Dorothy R. Kolb.

(a) RESIDENCE NO. Galloway Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
35		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer O&G

(b) General nature of industry, business, or establishment in which employed (or employer): Office

(c) Name of employer: Dr. I. J. Spear

9 BIRTHPLACE (city or town) (State or country): Galloway Md

PARENTS

10 NAME OF FATHER: John J. Kolb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Caroline Kirsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital records
(Address)

15 MAY 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/4 — 1922

17

I HEREBY CERTIFY, That I attended deceased from Apr-30, 1922, to May 4, 1922.

that I last saw h[illegible] alive on May 4, 1922.

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Ectopic with Hemorrhage resulting from Tubal pregnancy

NVW

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Pancreatitis Hepatitis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 4/30/22

Was there an autopsy? no

What test confirmed diagnosis? Op findings & Laboratory

(Signed) Newton G Parr, M. D.

5/4, 1922 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Galloway Md

DATE OF BURIAL: 5-4-1922

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64004

D 64004

CERTIFICATE OF DEATH.

135

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 10 WARD)

2-FULL NAME Mr. John Murnane

(a) RESIDENCE. NO. 1024 Brentwood ST. Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steelworker

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Murnane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Madigon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mercy Hospital Records

(Address)

15 Filed MAY 4 - 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 21, to May 3, 1922, that I last saw him alive on May 3, 1922, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows: Benign Prostatic Hypertrophy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 11/19/21

Was there an autopsy? no

What test confirmed diagnosis? Findings, Regional exam, Autopsy

(Signed) John J. Ewen, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 19

20 UNDERTAKER J. C. Friedfeld ADDRESS 914 Grun Mt. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR PERMANENT RECORD

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64005

CERTIFICATE OF DEATH.

164 D 64005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1410 Battery Ave (St.) (Ward) 24

2-FULL NAME Margaret Ann Adams

(a) RESIDENCE No. 1410 Battery Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Benjamin F. Adams

6 DATE OF BIRTH (month, day, and year): April 20 1853

7 AGE: Years 68 | Months | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Trumbo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Marion Trumbo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mr. E. Berger 1410 Battery Ave

15 Received ....., 19 ..... Registrar: Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to May 2 1922.

That I last saw h[illegible] alive on May 2 1922, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Debility

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) 340 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem't DATE OF BURIAL: May 5 1922

20 UNDERTAKER: William Cook 502 E. Baltimore ADDRESS

MAY 4 - 1922

Dr. Franklin [illegible]

WARNING—RESERVED FOR REGISTRATION DATE. A.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64006

CERTIFICATE OF DEATH.

X 181-001

D 64006

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 725 — N. Calvert ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Thompson

(Residence in Baltimore: No. 336 W. 5-5-18 St. A. H. Y St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 5 2 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) Oak

9-BIRTHPLACE, (State or Country), Indiana

PARENTS:

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER: Julia Thompson

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. B. Jowett

(Address) 725 N. Calvert St.

15-

Filed ....., 191 .....

Robert F. Morrison,

Registrar.

Burial Permit Clerk.

MAY 4-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquest..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ....inquest..... find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation by Illuminating Gas

Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicidal

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. T. Culley M. D.
(Coroner.)

May 4, 1922 (Address) 163 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn DATE OF BURIAL, May 6, 1922

20-UNDERTAKER Wm Cook ADDRESS 502 E. North ave

D 64007

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 64007

CERTIFICATE OF DEATH.

74-006

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Eliza J. Stewart.

(Residence in Baltimore: No. 118 W. Cross St. St.; yrs. 47 mos. ds.)

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Widow.

6-DATE OF BIRTH. May 4th. 1846. (Month) (Day) (Year)

7-AGE. 75 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Dorchester Co. Md.

PARENTS:

10-NAME OF FATHER. John T. Maguire.

11-BIRTHPLACE OF FATHER, (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Stewart. (son)

(Address) 118 W. Cross St.

15-

Filed MAY 4 1922

[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3rd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

May 3rd. 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? 118 W. Cross St.

Former or usual residence May 2nd. 1922.

19-PLACE OF BURIAL OR REMOVAL. Western Cem. DATE OF BURIAL. May 5th 1922

20-UNDERTAKER. E. Schloman & Son ADDRESS 1039 Hanover St.

Spec.—8-24-14—M. & T.—2000 Bks.

(Crutchfield) 101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64008

D 64008

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norelda [redacted] Crutchfield

(Residence in Baltimore: No. 2114 Brunan St St.; 1 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb (Month) 2 (Day) 1912 (Year)

7-AGE, 10 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Crutchfield

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sousa Hayden

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sousa Hayden

(Address) Washington D.C.

15-

Filed May 4, 1922 Robert [redacted] Harrison, Registrar.

Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day) 1922 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 2 1922 to May 3 1922 that I saw her alive on May 3 1922 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(Duration) yrs. mos. ds.

(Signed) [redacted] M. D.

191... (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Washington D.C. DATE OF BURIAL, May 5, 1922

20-UNDERTAKER John H Toadvine ADDRESS 142 W Fayette St

MAY 4 - 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64009

CERTIFICATE OF DEATH.

101-081

D 64009

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1601 Park Ave ST., 14 WARD)

2-FULL NAME Caleb R Kelly

(a) RESIDENCE NO. 1601 Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel N Kelly

6 DATE OF BIRTH (month, day, and year) Mar. 6 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Andrew J. Kelly

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Park Redgrave

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs Ethel N. Kelly (Address) 1601 Park ave

15 Filed [illegible] Registrar

Burial Permit Clerk.

MAY 4 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922, to May 3, 1922, that I last saw him alive on May 3, 1922, and that death occurred, on the date stated above, at 345 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Multiple Neuritis

(duration) ..... yrs. 2 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W W Hoyaard M. D.

May 4, 1922 (Address) 80 S Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL May 5 1922

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64010

CERTIFICATE OF DEATH.

31 D 64010

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Owens

(a) RESIDENCE. NO. 811 S. Green st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 years Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 080

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wilson Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Lankford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M. T. H.

15 MAY 4 - 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1921, to May 3, 1922,

that I last saw him alive on May 3, 1922,

and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and enteritis (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dadaglianca M. D.

5-3-22 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE AND DATE OF BURIAL, CREMATION OR REMOVAL Marlboro Md DATE OF BURIAL 5/7 1922

20 UNDERTAKER Fred Deale Baltimore Md 406 N Carey

ADDRESS

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64011

D 64011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 846 N Baltimore ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Imogene L Dooley

(a) RESIDENCE. No. 846 N Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: B N Dooley

6 DATE OF BIRTH (month, day, and year): May 10, 1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa.

PARENTS

10 NAME OF FATHER: J D Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Harriette Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia Pa

14 Informant (Address): Mrs N Wright 846 N Balto St.

15 Filed MAY 5 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1922, to May 6, 1922, that I last saw h[illegible] alive on May 3, 1922, and that death occurred, on the date stated above, at 1145 O m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) J M Lumpkin, M. D.

May 6 1922 (Address) 826 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: May 6 1922

20 UNDERTAKER: Mrs J E Evans & Son — ADDRESS: 1420 Edmondson

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

D 64012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

D 64012

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Langville Jr.

(Residence in Baltimore: No. 57 E. Randall St. St.; yrs. 8 mos. 4 ds. 12)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced. (Write the word.): Single.

6-DATE OF BIRTH: December 20th. 1913. (Month) (Day) (Year)

7-AGE: 8 yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): ood

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: George Langville Sr.

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Della J. Maddox.

13-BIRTHPLACE OF MOTHER, (State or Country): Salisbury, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Langville. Sr. (father)

(Address) 57 E. Randall St.

15- Filed MAY 5 - 1922

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall into the street from the running board of a moving automobile. (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto H. Reinhardt M. D.
(Coroner)

May 3rd 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? In front of 45 E. Randall St

Former or usual residence May 2nd. 1922.

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: May 5 1922

20-UNDERTAKER: Mat E Evans & Son ADDRESS 1425 E Charles St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64013

CERTIFICATE OF DEATH.

159-0 D 64013

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 N Collington Ave St.) (WARD 8)

2-FULL NAME James L Clark

(a) RESIDENCE No. 1917 N Collington Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 30th 1922

7 AGE — Years: — Months: 1 — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Walter F Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D C

12 MAIDEN NAME OF MOTHER: Stella Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Whiteland Ind

14 Informant: Stella L Clark

(Address): 1917 N Collington ave

15 Filed: MAY 5 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1922

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1922, to May 3, 1922,

that I last saw h alive on May 3, 1922,

and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Congenital Valvular Heart disease

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

May 5, 1922 (Address) 1823 N. Wash ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Delta Pa...

DATE OF BURIAL: May 5 1922

20 UNDERTAKER: Robt L Turner Inc

ADDRESS 1442 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

1-5-469 D 64014

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 64014

CERTIFICATE OF DEATH.

146

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " ST., 16 WARD)

2-FULL NAME Jane Chase

(a) RESIDENCE NO. 1010 Russell Terrace WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 25 1885

7 AGE — Years: 37 | Months: 1 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED 070

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Laundry about~~ ~~Factory~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 FILED MAY 5 - 1922 ROBERT R. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28th, 1922, to May 1st, 1922, that I last saw her alive on May 1st, 1922, and that death occurred, on the date stated above, at 6:20 p. m.

The CAUSE OF DEATH* was as follows:

Puerperal septicaemia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Puerperal peritonitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 1010 Russell Terrace

Did an operation precede death? Yes Date of 4-25-22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hattie E. Ward, M. D.

, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 5 1922

20 UNDERTAKER David Easter — ADDRESS 916 Fa ve

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

...LY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...ARGIN RESERVED FOR BINDING

Spec.—S-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64015

CERTIFICATE OF DEATH.

50 D 64015

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N. Monroe ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton E. Rannels

(Residence in Baltimore: No. 314 N. Monroe St Mon St.; 35 yrs., — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 6 (Month) (Day), 1868 (Year)

7-AGE, 53 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cassier Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): National Stemping Co

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Henry Rannels

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Sarah Rostetter

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rannels

(Address) 314 N. Monroe

15-Filed MAY 5 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day), 1922 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1921, to May 3 1922, that I saw him alive on May 3, 1922, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) ....yrs. 18 mos. ....ds.

CONTRIBUTORY (Secondary) Tumor of Anterior Mediastinum

(Duration) ....yrs. 6 mos. ....ds.

(Signed) E. J. Dickey M. D.

May 4, 1922 (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, May 5, 1922

20-UNDERTAKER Geo. Weber & Son — ADDRESS 2583 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 64016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64016

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 12 Gro Hospital St. 3 WARD)

REGISTERED NO. C 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard C Wiley

(Residence in Baltimore: No. 1629 S Sondard St; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	Col,	Married

6-DATE OF BIRTH, ... Unknown (Month) ..... 1 (Day) ..... (Year)

7-AGE, 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Cornelius Wiley

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Florence Gantry

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Florence Norris

(Address)... Marriottsville Md

15-

MAY 5 - 1922 ..., 191 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) ..... 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach trouble

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

5-4-, 1922 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Marriottsville Md — DATE OF BURIAL, April 22 1922.

20-UNDERTAKER Wm Leech — ADDRESS 502 E Mert ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64017

CERTIFICATE OF DEATH.

49 D 64017

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 W. Lombard ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Dell

(Residence in Baltimore: No. 1833 W Lombard St ST.; 52 yrs., mos. da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May (Month) 10 (Day), 1842 (Year)

7-AGE, 78 yrs. 11 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): 016

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Carl Dell

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Dell

(Address) 1833 W Lombard St

15-

Filed MAY 5 1922 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 4 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 1 1922, to May 4 1922, that I saw him alive on May 4 1922, and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Cancer of throat

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) 1 yrs. mos. ds.

(Signed) Chas A Lohaupt M. D.

May 4, 1922 (Address) 525 Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [illegible] Park — DATE OF BURIAL, May 6th, 1922

20-UNDERTAKER C F McCormick — ADDRESS 508 Lemon

Spec.—8-24-14—M. & T.—2000 Bks.

D 64018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64018

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E Cross ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Hirsch

(Residence in Baltimore: No. 117 E. Cross St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, January 23, 1842 (Month) (Day) (Year)

7-AGE, 80 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Levin

(Address) 117 E Cross St

15-

Filed MAY 5 - 1922, 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 24 1922, to May 2 1922, that I saw him alive on May 2 1922 and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. Lamb M. D.

May 3, 1922 (Address) 102 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, May 6, 1922

20-UNDERTAKER F. A. Krause & Son ADDRESS 703 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64019

CERTIFICATE OF DEATH.

49

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11-E-Chase-St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HARRY GARDNER

(a) RESIDENCE. No. 11-E-Chase-St. ST., 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? 71 yrs. 2 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minnie Hawthorne Gardner.

6 DATE OF BIRTH (month, day, and year) Feb-12-1851.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	21	

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work Retired Tobacco

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman for the

(c) Name of employer Marburg Tobacco Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Borius F. Gardner

11 BIRTHPLACE OF FATHER (city or town) York Springs
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Eliza A. Rogers

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia.

14 Informant Mrs. Albert Marburg (sister)
(Address) 11-E-Chase-St., City.

15 MAY 5 - 1922 S. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24th, 1922, to May 3rd, 1922, that I last saw h alive on May 3rd, 1922, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

about 1 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about 3 mos. ago
(Performed by Dr. Thurston Johns Hopkins Hosp.)
* Was there an autopsy? Cystoscopic exam. - no radical operation.
* Bladder removed for examination.

What test confirmed diagnosis?

(Signed) Wm F. Lockwood, M. D.

, 19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREEN MOUNT CEMETERY

DATE OF BURIAL: May-6-22

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64020

D 64020

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Mt Royal Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Father

(Residence in Baltimore: No. 1406 Mt. Royal Ave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 14 (Day), 18[illegible] (Year)

7-AGE, 78 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Bk Keeper

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. M. Peters

(Address) 801 Linden Ave

15- Filed MAY 5 - 1922 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1910, to date 1922, that I saw him alive on May 3 1922, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows: Dilatation of heart

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

(Signed) C. A. Gaboriel M. D.

191... (Address) 2413 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, China Grove N.C

DATE OF BURIAL, May 5, 1922

20-UNDERTAKER Chas. E. Franck

ADDRESS 802 Madison Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated in every case, even if very CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64021

CERTIFICATE OF DEATH.

90 D 64021

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 506 So Register ST.) V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Nowak

(Residence in Baltimore: No. 506 S Register St. 41 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, about 42 yrs old (Month) (Day) 1 (Year)

7-AGE, about 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Jacob Nowak

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Anna Sopazek

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mike Nowak

(Address) 710 Bond St

15- FILED MAY 5 - 1922 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. ds.

(Signed) Fred B. Horton M. D.
(Coroner)

(Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, May 6, 1922

20-UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64022

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 Whatcoat ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Stanton

(a) RESIDENCE. NO. 1217 Whatcoat ST., WARD. 45 Gen

(Usual place of abode) Like

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ordinary pen and ink. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9,	9,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Annie Gilmore

(Address) 1217 Whatcoat St

15 Filed MAY 5 - 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 23 1922. to May 3 1922.

that I last saw him alive on May 3 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Anasarca

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Dilatation of heart chronic

Mitral regurgitation (duration) — yrs. 4 mos. — ds. from history

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clark, M. D.

May 4, 1922 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 6 1922
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey St

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 64023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64023

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Calhoun ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Lab Line

2-FULL NAME Donald Gross

(a) RESIDENCE. NO. 917 N. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state nation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/19/03

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter in Bakery 070

(b) General nature of industry, business, or establishment in which employed (or employer) cleaning in general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Huntingtown Md.

12 MAIDEN NAME OF MOTHER Susie Makel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Huntington Md.

11 Informant (Address) James Gross 917 N. Calhoun St

13 Filed MAY 5 1922. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2 — 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1922, to May 2, 1922, that I last saw him alive on May 2, 1922, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Vascular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Marcellus E. Toney, M. D.

, 19 (Address) 1449 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 5 1922
20 UNDERTAKER	ADDRESS
Edward Ringgold	1463 Carey St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64024 — 14-B 64024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516½ Pine St ST.: 17 WARD)

2-FULL NAME Mary Atkinson

(a) RESIDENCE. No. 516½ Pine St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Atkinson

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cecil Md

PARENTS

10 NAME OF FATHER Anthony Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) James Atkinson 516½ Pine St

15 Filed MAY 5 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1922, to May 3rd, 1922, that I last saw her alive on May 3d, 1922, and that death occurred, on the date stated above, at 7:20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W Garrison Mardon M. D.

5/4 1922 (Address) 901 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ind Auburn Cmty — DATE OF BURIAL 5-6 1922

20 UNDERTAKER George H. Holland — ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS REQUIRED BY LAW. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64025

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

CERTIFICATE OF DEATH.

D 64025

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1550 Woodyear ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Bell

(Residence in Baltimore: No. 1550 Woodyear St.: Att 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 1888 (Month) (Day) 1 (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Labor

9-BIRTHPLACE, (State or Country), St Marys Co Md

PARENTS.

10-NAME OF FATHER, John Bell

11-BIRTHPLACE OF FATHER (State or Country), Baltimd

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimd

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Erma Bell

(Address) 1550 Woodyear

15- MAY 5 - 1922 ROBERT R. KNAUER, Registrar.

Filed MAY 5 - 1922 191 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1922, to May 3 1922, that I saw him alive on May 2 1922, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(Duration) yrs. mos. 2 ds.

(Signed) W. J. Coleman M. D.

May 3, 1922 (Address) 208 S Wolfe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 5-6-22

20-UNDERTAKER Filbert B Fox

ADDRESS 102 E Mulberry St

WRITE PLAINLY. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. INFORMATION as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64026

D 64026

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

1-PLACE OF DEATH Birth Ave Lakeland ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.....

2-FULL NAME Charlotte Lamana

(a) RESIDENCE. NO. Lakeland ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles P. Lamana

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mattie Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Charles P. Lamana (Address) Birch Ave Lakeland

15 Filed MAY 5 - 1922 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3 1922 to May 4 1922, that I last saw her alive on May 3 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) no yrs. no mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Complete.

(Signed) Rudolph Lukeland M. D.

(Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cem DATE OF BURIAL May 6' 1922

20 UNDERTAKER Jos Joerdens Son ADDRESS 2173 Bon

Spec.—1-10-21—M&T—1500 Blks.

D 64027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64027

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Somerset ST., 10 WARD)

2-FULL NAME Annie C. Fryer

(a) RESIDENCE NO. 1003 Somerset ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or ~~WIFE of~~): Conrad Fryer

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: about — Years: 54 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Andrew Frang.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Conrad Fryer

(Address) 1003 Somerset St

15 Filed MAY 5 - 1922, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to May 4, 1922, that I last saw her alive on May 4, 1922, and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

(Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 6 1922

20 UNDERTAKER: Henry Kruck & Son — ADDRESS: 1301 E. Eag. St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 64-1922 B.C.C. 250 Bks.

D 64028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64028

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Seitz

(a) RESIDENCE. No. 1434 N. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Seitz -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer -

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Wm. A. Seitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany -

12 MAIDEN NAME OF MOTHER Barbara Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany -

14 Informant (Address) Hospital Records

15 Filed MAY 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922, to May 5, 1922, that I last saw h[illegible] alive on May 5, 1922, and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis -

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Examination -

(Signed) R. B. Jones, M. D.

5/5 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 8 1922
20 UNDERTAKER	ADDRESS
Henry Houck & Son	1307 E Eag[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 64029

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Royal Apts ST.; 11 WARD)

2-FULL NAME Elizabeth Agnes Gavin

(a) RESIDENCE. NO. 111 Royal Apts ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE BLANKS MUST BE FILLED AND ALL INFORMATION should be stated EXACTLY. PHYSICIANS AND UNDERTAKERS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, ~~or divorced~~ (or) WIFE of Richard Gavin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) County Westmeath Ireland

PARENTS

10 NAME OF FATHER Lawrence Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westmeath Ireland

12 MAIDEN NAME OF MOTHER Mary Roland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westmeath Ireland

14 Informant: Richard Gavin (Address) Baltimore Md

15 Filed MAY 5 - 1922 J. E. Wehn Registrar

MAY 5 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to 5/3, 1922, that I last saw h[illegible] alive on 5/3, 1922, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis,
Dysphasia,

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aspiration Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) [illegible] M. D.

5/4, 1922 (Address) 408 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL May 6 1922

20 UNDERTAKER Fenwyck Hawkins & Sons Co — ADDRESS McCulloh Orchard

Spec.—1-10-21—M&T—1500 Bks.

D 64030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64030

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Washington ST., 2 WARD)

2-FULL NAME William F. South

(a) RESIDENCE NO. 120 S. Washington ST., 2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer William F. Jacobs

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas South

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Jacobs

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant (Address) William F. Jacobs 120 S. Washington St

15 Filed 19 Robert P. [redacted], Registrar

MAY 5 - 1922

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to May 3, 1922, that I last saw him alive on May 2, 1922 and that death occurred, on the date stated above, at 10 55 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Geo. Heller, M. D.

5.5.1922 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL May 6 1922

20 UNDERTAKER H. Sander & Sons — ADDRESS 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64031

CERTIFICATE OF DEATH.

REGISTERED NO. 99

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3020 Elliott ST., 1 WARD)

2-FULL NAME James P. Mullaney

(a) RESIDENCE NO. 3020 Elliott ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas P. Mullaney

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose A. Moran

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Thomas P. Mullaney (Address) 3020 Elliott St

15 Filed MAY 5 - 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922 to May 4, 1922

that I last saw him alive on May 4, 1922

and that death occurred, on the date stated above, at 10 1/2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) related heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) M. J. McAvoy, M. D.

May 5 1922 (Address) 639 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stanford Road Holy Cross Cemetery. DATE OF BURIAL May 6 1922

20 UNDERTAKER H. Sanders Sons ADDRESS 710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT EXACTLY. PHYSICIANS should be careful in the statement of CAUSE OF DEATH. AGE should be stated EXACTLY. OCCUPATION should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64032

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 N. Caroline ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emaline Northern

(Residence in Baltimore: No. 613 Walker St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1 (Year) R.D.

7-AGE, 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Leas Harris.

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Amil Harris

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Northern

(Address) 613 Walker St.

15-

Filed MAY 5 - 1922, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 4 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/1 1922, to 5/4 1922, that I saw h[illegible] alive on May 4, 1922, and that death occurred, on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Johnston's

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) High blood pressure

(Duration) yrs. 3 mos. ds.

(Signed) Jno. E. Robinson M. D.

5/7, 1922 (Address) 652 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Laurel Cemetery DATE OF BURIAL, May 7, 1922

20-UNDERTAKER Chas. H. Simon ADDRESS 710 N. Caroline St.

B.—Every item of information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64033

D 64033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 619 Melville Ave. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patricia Marie Gibson

(a) RESIDENCE NO. 619 Melville Ave. ST., WARD Panama

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? 3 yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Panama.

PARENTS

10 NAME OF FATHER Archie Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Gertrude Lorenz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Archie Gibson

(Address) 619 Melville Ave.

15 Filed ....., 19 .....

Registrar

MAY 5 - 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1922 to May 4, 1922

that I last saw her alive on May 4, 1922

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F F Wolfrundra M. D.

5-4, 1922 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL May 5 1922.

20 UNDERTAKER Selby and Zeiler.

ADDRESS 403 S Wolfe St

I. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. In CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64034

CERTIFICATE OF DEATH.

D 64034

129

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 700 Woodbourne ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie May Howser.

(a) RESIDENCE. No. 700 Woodbourne ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grover C Howser

6 DATE OF BIRTH (month, day, and year) Aug 21-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co (State or country) Md

PARENTS

10 NAME OF FATHER Beal Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Lavinia Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md

14 Informant Grover C Howser
(Address) 700 Woodbourne ave

15 Filed ....., 19.....
Robert P. Harrison, Registrar
Burial Permit Clerk.

MAY 5 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1920, to May - 4, 1922, that I last saw h.. alive on May 4, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chron Interstitial Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Howes, M. D.

5-5-1924 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 6 1922
20 UNDERTAKER	ADDRESS
John O. Mitchell	1701 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

154930

D 64035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 64035

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. .. ST. .. WARD) 6

2-FULL NAME Samuel H. Franklin.

(a) RESIDENCE NO. 106 N. Ann St. City, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Julia Franklin (wife)

6 DATE OF BIRTH (month, day, and year) Sept 12, 1857

7 AGE: Years 64 Months 7 Days 12. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler Maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Samuel H. Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Frances Wotten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant JOHNS HOPKINS HOSPITAL Records. (Address)

15 May 5, 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to May 4, 1922, that I last saw him alive on May 4, 1922, and that death occurred, on the date stated above, at 11.5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute pyelo-nephritis

(duration) 0 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md

Did an operation precede death? 0 Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Franklin P. Johnson, M. D.

1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: May 6 1922

20 UNDERTAKER: Lilly & Geiser — ADDRESS: 405 E. Monument

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64036

CERTIFICATE OF DEATH.

46

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Fulton Ave ST.: 20 WARD)

2-FULL NAME Mrs Margaret A Grady.

(a) RESIDENCE. NO. Fulton Ave and Franklin ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Grady

6 DATE OF BIRTH (month, day, and year) May 29-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER David Beal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Charlotta Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt Washington Md.

14 Informant (Address) Harry M. Grady 1430 Hollins St

15 Filed 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from January 27 1922 to May 4 1922

that I last saw her alive on May 3 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto intoxication

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George C. Shannon M. D.

5/4. 1922 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 6 1922
20 UNDERTAKER George J. Smith	ADDRESS 1000 N. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in stating cause of death. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 64037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64037

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 E. North Ave. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Handley

(a) RESIDENCE. NO. 1738 E. North Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William E. Handley

6 DATE OF BIRTH (month, day, and year) June 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. V. Kraio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Kellar Handley

(Address) 1738 E. North Ave.

15 Filed ... 19... Robt. F. Harrison, Registrar

(Burial Permit Clerk.)

MAY 5-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4, 19 22

17

I HEREBY CERTIFY, That I attended deceased from May 3d, 1922, to May 4th, 1922, that I last saw h[illegible] alive on May 4, 1922, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegy

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Chronic Interstitial Nephritis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The symptoms were

(Signed) Charles Lee, M. D.

May 5. 1922 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 5/6 19 22

20 UNDERTAKER: J. Frew McCully

ADDRESS: 130 E. Fort Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should give information asked for AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64038

D 64038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 E Lafayette Ave ST.; 8 WARD)

2-FULL NAME Jeannette Houck

(a) RESIDENCE. No. 1813 E. Lafayette Ave ST.; ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Elmer Houck

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore-

PARENTS

10 NAME OF FATHER John Henry Bittinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Louise Boerer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newport N. C.

14 Informant Elmer Houck (Address) 1813 E Lafayette Ave

15 Rob't P. Harrison. Registrar

Burial Permit Clerk.

MAY 5 - 1922

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17

I HEREBY CERTIFY, That I attended deceased from April 3, 1922, to May 4, 1922, that I last saw her alive on May 4, 1922, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. Hamman M. D.

, 19 (Address) 2500 E Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	5/8/1922

20 UNDERTAKER ..... ADDRESS .....

E. D. Fanning & Son 1938 E. Lafayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64039 D 64039

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Forrest ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Nace

(Residence in Baltimore: No. 210 Forest St.; ...yrs.,...mos.,...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-[illegible], MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: June 27 (Month) (Day), 1877 (Year)

7-AGE: 44 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John L. Tampley

11-BIRTHPLACE OF FATHER (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene Nace

(Address) 210 Forrest St

15-

Filed ..., 191...

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAY 5 - 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: May (Month) 3 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 18 1922, to May 3 1922, that I saw h[illegible] alive on May 2 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Naso-Pharynx

(Duration) 1 yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary): Exhaustion

(Duration) ...yrs. ...mos. 14 ds.

(Signed) Adolph C. Eisenberg M. D.

May 4, 1922 (Address) 2201-03 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 5/6/1922

20-UNDERTAKER: C. D. Fanning & Son — ADDRESS: 1386 Lafayette

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64040

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64040

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (a) WARD. NO. 434 E Fort Ave ST.: 24 WARD)

2-FULL NAME Carrie Schwartz

(a) RESIDENCE. NO. 434 E Fort Ave ST., 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1. 28. 1845

7 AGE 77 Years 3 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Midwife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(r) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Burkhorn 434 E Fort Ave. (Daughter)

15 Filed MAY 5 - 1922 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from 4. 24, 1922, to 5. 4, 1922, that I last saw her alive on 5. 4, 1922, and that death occurred, on the date stated above, at 3. a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Dis (Myocarditis)

from History (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. Turlington, M. D.

, 19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 5/6/1922

ADDRESS

20 UNDERTAKER C I Fanning 1760 Bellona

B.—WRITE PLAINLY, WITH UNFADING INK—THIS ... should be stated EXACTLY. PHYSICIAN'S ... should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be given, so that it may be properly classified. Exact statement of OCCUPATION should be given, so that it may be properly classified. Exact statement of OCCUPATION should be given, so that it may

Spec.—1-10-21—M&T—1500 Bks.

Evans

D 64041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64041

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 70 Linden Ave ST., Baltimore Md (WARD) 13

2-FULL NAME Mary Elizabeth Evans

(a) RESIDENCE NO. 70 Linden Ave ST., Balto WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? 84 yrs. 6 mos. 1 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: William Evans

6 DATE OF BIRTH (month, day, and year): Sept 18 1837

7 AGE: Years 84 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. Mary Evans 70 Linden Ave Balto Md

15 MAY 6 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 5, 1922, that I last saw h[illegible] alive on May 5 - 1922, 1922, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocardial acute

(duration) X yrs. X mos 2 ds.

CONTRIBUTORY (Secondary): Senility (duration) 2 yrs. 6 mos. X ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? examination

(Signed) A. F. Bigger M. D.

May 6, 1922 (Address) 6010 York Road Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Poplar Balto Co — DATE OF BURIAL: May 9 22

20 UNDERTAKER: Chenaweth & Son Chestnut — ADDRESS: [illegible]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64042

D-64042

CERTIFICATE OF DEATH.

REGISTERED NO. 51

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin Thompson

(a) RESIDENCE NO. 710 Puritan St ST., WARD 7

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Julian Thompson

6 DATE OF BIRTH (month, day, and year) Jan 25 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	25	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nannie Birney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

15 Filed MAY 6 - 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19. 1922. to ~~Dec.~~ May 4. 1922

that I last saw him alive on May 4 1922

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Rheumatic pancarditis.

(duration) yrs. 1½ mos. ~~days~~ ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(duration) Indefinite yrs. mos. a few ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Florido, M. D.

, 192 2 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL May 8 1922

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut Ave

IAN, B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D 64043

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 64043

74,001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1616 Madison Ave ST.: 14 WARD)

2-FULL NAME Henry Edward Lupus

(a) RESIDENCE. NO. 1616 Madison Av ST., 14 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly May Lupus

6 DATE OF BIRTH (month, day, and year) November 8, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	4	6 hrs. 31 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country) U.S.A.

PARENTS

10 NAME OF FATHER Rudolph Lupus

11 BIRTHPLACE OF FATHER (city or town) Homberg (State or country) Germany

12 MAIDEN NAME OF MOTHER Emilie Miller

13 BIRTHPLACE OF MOTHER (city or town) Homburg (State or country) Germany.

11 Informant Mrs Henry E Lupus (Address) 1616 Madison ave

15 Filed MAY 8 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to May 4, 1922, that I last saw him alive on May 4, 1922, and that death occurred, on the date stated above, at 6.31 9. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) ? yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Fenby, M. D.

5/4, 1922 (Address) 3572 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 5/6 1922

ADDRESS 12-14 N Gay St

20 UNDERTAKER [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS ENTIRE CERTIFICATE MUST BE FILLED OUT EXACTLY. PHYSICIANS AND OTHERS REPORTING DEATHS are requested to be specific in answering the questions on this certificate. All items should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. Exact information should be given in plain terms, so that it may

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64044

D 64044

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N. Bamstar St., Ward 10)

2-FULL NAME William Henry Jennison

(a) RESIDENCE NO. 911 N. Bamstar St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara H. Jennison

6 DATE OF BIRTH (month, day, and year): Mar 30 1882

7 AGE: Years 40 Months 9 Days 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Foundry

(c) Name of employer: Smith & Dixon

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Clara H. Jennison 731 W Franklin

15 Filed ..... 19 ..... Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15th 1921 to May 3rd 1922

that I last saw h alive on May 3rd 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 724 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: May 6 1922

20 UNDERTAKER: David Eccles

ADDRESS 916 Park

MAY 6 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE MUST BE FILLED EXACTLY. PHYSICIANS should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64045

CERTIFICATE OF DEATH.

38 ✓ D 64045

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 822 Fremont St., 10 WARD)

2-FULL NAME Gladys Martin

(a) RESIDENCE NO. 822 Fremont St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS CERTIFICATE must be filled out EXACTLY. PHYSICIANS' information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced. (Write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer Mrs Donaghue

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alex. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lethia Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elsie Cutlings

(Address) 822 Fremont Ave

15 Filed MAY 6 - 1922, 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1922, to May 5, 1922

that I last saw h[illegible] alive on May 3, 1922

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH was as follows:

Acute Mania (Duration) Chronic many months indefinite

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? Mental Exam

(Signed) R. Garland Schmidt M. D.

May 4 1922 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn Md DATE OF BURIAL May 6 1922

20 UNDERTAKER Arnold Eccles ADDRESS 516 Park Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

In trying to find out
just why [illegible] woman
became abrupt and finally
a maniac the family history
is very indefinite [illegible]
information obtainable [illegible]
some indication [illegible]
she was syphilitic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Glaser

D 64046

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 64046

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1102 N. Potomac ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Glaser

(a) RESIDENCE. No. 1102 N Potomac ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward A Glaser

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Margaret B Ginglein

(Address) 1102 N Potomac St

15 Filed Robert P. Harrison, Registrar

MAY 6 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3d 1922

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to May 3d, 1922, that I last saw h alive on May 3d, 1922, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Coronary

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward C. Ebert, M. D.

, 19 (Address) 3706 Eldorado Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	May 7 1922
20 UNDERTAKER H. Sander & Sons	ADDRESS 1210 Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS [illegible] PHYSICIANS should be careful in the information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64047

CERTIFICATE OF DEATH.

31

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 335 So. 13½ ST.; 76 WARD)

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Adams

(Residence in Baltimore: No. 335 S. 13½ St.; 10 yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, July 11 1882
(Month) (Day) (Year)

7-AGE, 40 yrs. 9 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 086
(a) Trade, profession, or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) On tug boat

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Andrews Sr

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Davis

(Address) 335 So. 13½ St

15- Robert P. Harrison,
....., 191.....
Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

May 4th 1922. (Address) Coates Bldg.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, May 6, 19...

20-UNDERTAKER H. Vander & Sons

ADDRESS 710 Park St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, HOURS or MINUTES must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 6 - 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64048 D 64048

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1736 Baker (St.) (15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elaynia Duppins

(a) RESIDENCE. NO. 1736 Baker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Clarence Duppins

6 DATE OF BIRTH (month, day, and year): Nov. 6, 1891

7 AGE: Years 30 Months 5 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick County, Md.

PARENTS

10 NAME OF FATHER: Josephus Key

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick County Md.

12 MAIDEN NAME OF MOTHER: Mary Ella Coates

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick County Md.

14 Informant (Address): Josephus Key 1532 Leslie St

15 Filed MAY 6 - 1922 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1921, to May 3, 1922, that I last saw h.e alive on May 3, 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

5/5, 1922 Address) 1507 N. Dulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Bridge State Cabrol Co. Md. DATE OF BURIAL: May 7 1922

20 UNDERTAKER: Edward Ruggold ADDRESS: 1462 Carey

Spec.—1-10-21—M&T—1500 Blks.

D 64049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64049

CERTIFICATE OF DEATH

161

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Baby Slatterry

(a) RESIDENCE NO. 1425 Eastern Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—The items, marked with an asterisk (*), must be stated EXACTLY. PHYSICIANS should be careful in the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 26, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or — min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Slatterry

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine McDonald

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL Records. (Address)

15 Filed MAY 8 - 1922 MAY 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 26, 1922, to Apr. 27, 1922, that I last saw her alive on Apr 27, 1922, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

MAY 4

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64050

D 64050

CERTIFICATE OF DEATH.

REGISTERED NO. 32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2830 Clifton Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred C. Nickell

(a) RESIDENCE. NO. 2830 Clifton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec. 14- 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Orr W Nickell

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Edna Meagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Orr W Nickell
(Address) 2830 Clifton Ave

15 Filed MAY 6 - 1922 Robert P. Harrison, Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 5, 1922, that I last saw h[illegible] alive on May 5, 1922 and that death occurred, on the date stated above, at 9.35 A m.

The CAUSE OF DEATH* was as follows:

Intussusception Mesenteric

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 5 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym

(Signed) Fred O Fennel, M. D.

, 19 (Address) 2570 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL May 8 1922

20 UNDERTAKER Martin Fahey & Son — ADDRESS 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64051

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 D 64051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Redwood ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Gross

(a) RESIDENCE NO. 630 Redwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sep. 10, 1912

7 AGE — Years: 9 — Months: 7 — Days: 24 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm H Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Helen Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm H Gross (Address) 630 Redwood St

15 Filed MAY 6 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1922, to May 4, 1922, that I last saw her alive on May 1, 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. D. Howells M. D.

5/6, 1922 (Address) 1197 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: May 6 1922

20 UNDERTAKER: Samuel Hemsley

ADDRESS: 558 N Eddy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

13566 64052

CERTIFICATE OF DEATH.

31 D 64052

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. .. .. .. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Harris,

(a) RESIDENCE NO. 520 W. Biddle St. City, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Harris (father)

6 DATE OF BIRTH (month, day, and year) Sept ? - 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	4	10	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Harris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lizzie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL.

(Address) Riverdale.

15 Robert [illegible] Registrar

MAY 6 - 1922 . 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3 . 1922 to May 4 . 1922.

that I last saw him alive on May 4 . 1922

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 2 mos ? ds.

CONTRIBUTORY (Secondary)

none (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Tubercle bacilli in the urine

(Signed) T B Kay, M. D.

. 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Local DATE OF BURIAL MAY 6 1922

20 UNDERTAKER Samuel T. Hemsley ADDRESS 578 W Biddle

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64053

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 763 Vine (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Thomas Jr.

(a) RESIDENCE. NO. 763 Vine St ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Blanche Thomas

6 DATE OF BIRTH (month, day, and year) Unknown 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 804

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jas. A. Thomas Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harriett Thomas

(Address) 763 Vine St

MAY 6 - 1922 . 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15 . 1922 . to May 3 . 1922

that I last saw h im alive on May 3 . 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis DOW

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman . M. D.

May 5. 1922 (Address) 2687 Mckean Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL MAY 6 1922

20 UNDERTAKER Samuel Townsley

ADDRESS 578 N Bid dle st

P.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be given EXACTLY. Full information should be carefully supplied. AGE should be given EXACTLY. Fill in all items. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cert 3043

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 64054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64054

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St. Eutaw ave 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Matilda Gontrum

(a) RESIDENCE. No. Cor Farley & Alfred Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 5th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) America Baltimore Md

PARENTS

10 NAME OF FATHER John Gontrum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Gontrum
(Address) Farley & Alfred Ave. Ruxton

15 Filed , 19 Registrar

MAY 6 - 1922

Robert P. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5-22 19

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922, to May 5, 1922, that I last saw her alive on May 5, 1922, and that death occurred, on the date stated above, at 3:47 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles Bayley, M. D.

, 19 (Address) Latrobe apts, Balt., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gontrum Family Cemetery	May 8th 1922
20 UNDERTAKER	ADDRESS
Fred Lauchheimer & Sons	Fullerton Md

F. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64055 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 117 REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene St. 5 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Bell Hewett

(a) RESIDENCE. NO. Dundalk Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John Hewett

6 DATE OF BIRTH (month, day, and year): ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Cockran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Tyler Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs Cora Bell Hewett Dundalk Md

15 Filed MAY 6 - 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-5 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1922, to 5-5, 1922, that I last saw her alive on 5-5, 1922, and that death occurred, on the date stated above, at 8.35 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-27-22

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) K. B. Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury M E Cemetery Perryville Md

DATE OF BURIAL: May 7 19 22

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light St

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64056

D 64056

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4182 Belair Rd ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Polashek

(a) RESIDENCE NO. 4182 Belair Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Polashek

6 DATE OF BIRTH (month, day, and year) 12-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 184

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Polashek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Heil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Polashek

(Address) 4182 Belair Rd

15 Filed ..... 19 ..... Registrar

MAY 6 - 1922

Robert F. Leppert
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1921, to May 5th, 1922,

that I last saw h[illegible] alive on May 4th, 1922

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary th.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Gustave A. Fritz, M. D.

5/5, 1922 (Address) Cooks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL May 1922

20 UNDERTAKER William Cook ADDRESS 527 E Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64057

118-00 D 64057

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Infirmary ST., 17 WARD)

CITY OF BALTIMORE: (No.....

2-FULL NAME William Cowan, Jr

(a) RESIDENCE NO. 17 E. Lafayette ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Singer

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. md.
(State or country)

PARENTS

10 NAME OF FATHER Wm Cowan

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Vernie Lester

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Wm Cowan Sr.
(Address) 17 E. Lafayette ave.

15 Filed ....., 19..... Registrar

MAY 6 - 1922

Robert P. Garrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 22, to May 6, 19 22.

that I last saw h.. alive on May 6, 19 22,

and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 6 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted (?)
if not at place of death?

Did an operation precede death? yes Date of May 2, 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Cayetano Bustillo M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL 5/8/ 1922

20 UNDERTAKER Wm Cook, 502 E. North — ADDRESS ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT BEFORE BURIAL PERMIT IS ISSUED. PHYSICIANS SHOULD BE CAREFUL THAT ALL INFORMATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD BE CAREFUL THAT ALL INFORM

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64058

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. Daily

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31st 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Daily (?)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Josephine E Satterfield

13 BIRTHPLACE OF MOTHER (city or town) Easton (State or country) Md

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Balto Md

15 Filed MAY 6 1922, 19 Robert E. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1900, to May 5th, 1922, that I last saw h[er] alive on May 5th, 1922, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

abt (duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Dementia Post Chr. Mania abt (duration) 22 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 5th, 1922 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral May 6— 1922

DATE OF BURIAL

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Granni

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64059

CERTIFICATE OF DEATH.

117 D 64059

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.....WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin E Cooper.

(a) RESIDENCE. NO. 20 South Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Carrie Cooper

6 DATE OF BIRTH (month, day, and year) Dec. 27 1895.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Reporter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER James C. Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Kate Nash.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Carrie Cooper (Address) 20 S Broadway

15 Filed MAY 8 - 1922 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 28 1922 to May 5, 1922.

that I last saw him alive on May 5, 1922

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis.
Peritonitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

Carcinoma Colon (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 20 S. Broadway.

Did an operation precede death? Yes Date of April 28 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John W Whitehead, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	5-8- 1922
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64060

CERTIFICATE OF DEATH.

REGISTERED NO. C 161 D 64060

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 Williams Dr ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Hines Jr

(Residence in Baltimore: No. 1241 William St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May 24, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm H. Hines

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Martha Hines

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. Hines

(Address) 1241 Williams St

15-

Filed Nov 1 1922 Robert L. Harrison Registrar.

Nov 1 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 24 1922, to May 4th 1922, that I saw h.... alive on May 4th 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pernicious Enteritis

(Duration) ....yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Mucous Colitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry B Hall M. D.

May 4th, 1922 (Address) 1203 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Cross W & Co.	May 6, 1922
20-UNDERTAKER	ADDRESS
Jno. F. Tabler & Bro	1318 Light St.

B.—Every item of information should be carefully considered, properly classified. Exact statement of OCCUPATION may be important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64061

D 64061

CERTIFICATE OF DEATH.

REGISTERED NO. 32

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " " ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irwin Schario

(a) RESIDENCE NO. 908 Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 9-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Irwin Schario

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Katherine Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Record

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MAY 6 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 19 22

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26th 19 22 to May 8th 19 22

that I last saw him alive on May 8th 19 22

and that death occurred, on the date stated above, at 1:20 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

Carcinoma (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. B. Sey, M. D.

, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery DATE OF BURIAL May 8, 1922

20 UNDERTAKER Elmer H. Conklin ADDRESS 1242 E. Eager St.

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should

D 64062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64062

CERTIFICATE OF DEATH

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (D.....1616 Shakespeare.....St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Albert Schultz.....

(Residence in Baltimore: No. 1616 Shakespeare St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: W

5-CONDITION: Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH.....(Month).....(Day).....(Year)

7-AGE: 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE (State or Country): Germany

PARENTS:

10-NAME OF FATHER: Not known

11-BIRTHPLACE OF FATHER (State or Country):

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Apr 28 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Arteriosclerosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed).....M. D. (Coroner)

192.. (Address).....

"State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. MAY 1922

20-UNDERTAKER. Undertaker ADDRESS

FOR THE MORGUE.

N. B.—Every item of information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Y 8 - 1922

D 64063 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64063

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Asylum Registered No. C.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Smith

(Residence in Baltimore: No. 214 E Eutaw St.; yrs., ... mos. ..... ds.)

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, in filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	C	S

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1 (Year)

7-AGE. 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or. ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer). Odd

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Wm Dunn

11-BIRTHPLACE OF FATHER. (State or Country). ✓

12-MAIDEN NAME OF MOTHER. ✓

13-BIRTHPLACE OF MOTHER. (State or Country). ✓

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jay Finn

(Address) .....

15- MAY 6-1922 Robert P. Barrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 2 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia,

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Slade M. D.
(Coroner.)

May 3 1922 (Address) 22 E Eutaw St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. [illegible] ADDRESS MAY 1922

UNIVERSITY OF MARYLAND.

TO THE MORGUE.

(Green)

D 64064 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64064

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Asylum St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Negro Female Not known

(Residence in Baltimore: No. ... St.; yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. C—

5-CONDITION. Single, Married, Widowed, or Divorced. (Write the word.) S—

6-DATE OF BIRTH. —

(Month) (Day) (Year)

7-AGE. 60 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). ... 040

9-BIRTHPLACE. (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER. (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER. (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bay View

(Address) ...

15- Filed ... 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr 26 (Month) (Day) 22 (Year) 192...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and find that said deceased came to death on the day stated above. (autopsy or inquiry.)

The CAUSE OF DEATH was as follows:

*Arterio Sclerosis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senile Infirmities

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

(Coroner)

1922 (Address) ...

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. ... 19...

20-UNDERTAKER. ADDRESS ...

MAY 6 1922

UNIVERSITY OF MARYLAND MORGUE

8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Unknown state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 6 - 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64065 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64065

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Westport

CITY OF BALTIMORE: (No. 11 Maryland Ave ST.; 25 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence C. Mahl

(a) RESIDENCE. No. 11 Maryland Ave ST., Westport WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Mahl

6 DATE OF BIRTH (month, day, and year) Dec 23 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Hadel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William Mahl (Address) Westport

15 Filed MAY 6 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1922

17 I HEREBY CERTIFY, That I attended deceased from 12 or 1921, to May 5 1922, that I last saw h[illegible] alive on May 5 1922, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) general paralysis

(duration) 2 yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? urinary test

(Signed) [illegible] M. D.

May 6, 1922 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	May 8 1922

20 UNDERTAKER Tobias Supplee ADDRESS [illegible] Fourth Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 64066

CERTIFICATE OF DEATH.

90 D 64066
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2507 McHenry ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edgar Green

(a) RESIDENCE. (Usual place of abode) NO. 2507 McHenry ST., 20 WARD.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Smith

6 DATE OF BIRTH (month, day, and year) Mar. 18 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinest
(b) General nature of Industry, business, or establishment in which employed (or employer) Retired 031
(c) Name of employer Henry Green

9 BIRTHPLACE (City or town) (State or country) Balto. Md

PARENTS
10 NAME OF FATHER John Green
11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto. Md
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto. Md

14 Informant Fanny N. Green
(Address) 2507 Mc Henry St

15 Filed 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 3 1922

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1922 to May 3, 1922
that I last saw him alive on May 3, 1922
and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
Rheumatism (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Asa L Wessels, M. D.
5,4. 1922 (Address) 2565 Frederick ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rudgie Cemetery	May 6 19 22
20 UNDERTAKER	ADDRESS
F. B. Kirkpatrick	2236 Eutaw Pl

MAY 6—1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of Occ CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

64067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: 6 WARD)

2-FULL NAME Babe Oglesby

(Residence in Baltimore: No. 304 N. Bethel St.; yrs., mos. ds.)

Lived in Balto 6 years

REGISTERED No. C 64067

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Lafayette Hotel

9-BIRTHPLACE, (State or Country), N. C

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs Mary Oglesby

(Address)..... 304 N. Bethel

15-

MAY 7 - 1922 191. ROBERT R. KRAUTER,
Registrar.

Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Frontal Bone
Fracture Skull
Dislocated Vertebra
about 19 days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Surgeons
Sundays (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

May 5, 1922 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 19 days ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	May 7, 1922
20-UNDERTAKER Wm R A Elliott	ADDRESS 1725 Lakland St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

64068 64068

HEALTH DEPARTMENT—CITY OF BALTIMORE

64068

74 - D 64068

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 817 N Collington Ave ST.: 7 WARD)

2-FULL NAME John Novak

(a) RESIDENCE. NO. 817 N Collington ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Novak

6 DATE OF BIRTH (month, day, and year) .....

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Barth Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rudolph Novak

(Address) 2100 Eastlawn

15 Filed MAY 7 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 4, 19 22 to May 5, 19 22,

that I last saw him alive on May 4 19 22,

and that death occurred, on the date stated above, at 6.40 a.m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) ..... yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Novak, M. D.

, 19 (Address) 821 N. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakdale

DATE OF BURIAL May 7 1922

20 UNDERTAKER Frank Crockford

ADDRESS 1906½ Eden

N. B.—WRITE PLAINLY. WORDS SHOULD BE SPELLED OUT. AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in giving information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

64069 ✓ 64069

HEALTH DEPARTMENT—CITY OF BALTIMORE

64069 D 64069 90 D 64069

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 718 N Duncan ST.: 1 WARD)

2-FULL NAME Mary Skarda

(a) RESIDENCE. NO. 718 N Duncan ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Skarda

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 67; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: John Rada

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Jamen Skarda 718 N Duncan

15 Filed MAY 7 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1922 to May 5, 1922

that I last saw her alive on May 4, 1922

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

End paralysis (Alcohol Injection) Infarct (acute) Hypertension

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) M. Myerberg, M. D.

5-6, 1922 (Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 8 1922

20 UNDERTAKER: Frank Trackson — ADDRESS: 1906 Eastern

—WRITE PLAINLY. All items must be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Information should

Spec.—1-10-21—M&T—1500 Blks.

D 64070

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 - D 64070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2101 E Baltimore ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Merian Goldberg

(a) RESIDENCE NO. 2401 E Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 42 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Hyman Buckner

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 86 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Baltimore St

15 Filed MAY 7 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk, (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/6/1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 6, 1922, that I last saw h alive on May 4, 1922, and that death occurred, on the date stated above, at 3.9 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Samuel Weltchez M. D.

, 19 (Address) 1391 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Friendship — DATE OF BURIAL: 5-7 1922

20 UNDERTAKER: Jack Lewis, 1439 E Bala — ADDRESS

N. B.—WRITE PLAINLY, with ink. All questions must be answered. AGE should be stated EXACTLY; PHYSICIANS should be careful in stating the CAUSE OF DEATH. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should be careful in stating the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64071

CERTIFICATE OF DEATH.

X44 D 64071

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1117 Division St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Max Silverman

(a) RESIDENCE. NO. Woodlawn, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White (Russian Jew)	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Silverman

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Silverman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Bertha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jacob Lewis 1439 E. Balto. St.

15 Filed , 19 Registrar

MAY 7 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1922, to May 6, 1922, that I last saw h.~~im~~ alive on May 6, 1922, and that death occurred, on the date stated above, at 12.50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver, primary

Unknown (duration) yrs. 2½+ mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/4/22

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) H. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Athow Rosedale	May 7 1922
20 UNDERTAKER	ADDRESS
Jacob Lewis	1439 E Balto

N. B.—WHILE ALL INFORMATION should be carefully supplied, AGE should be stated EXACTLY. THIS INFORMATION should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Julia Fernheimer

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64072

D 64072

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 E Pratt St.: W WARD)

2-FULL NAME Julia Fernheimer.

(a) RESIDENCE. No. 2033 E. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lazarus Fernheimer

6 DATE OF BIRTH (month, day, and year) Germany

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Israel Isenberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Mehrer.

13 BIRTHPLACE OF MOTHER (city or town) Germany.
(State or country)

14 Informant Irene Fernheimer.
(Address) 2033 E. Pratt St.

15 MAY 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1922 to May 4 1922, that I last saw h[illegible] alive on May 4 1922, and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) — yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Laboratory Findings

5/5/22 H. C. Slade, M. D.

(Address) 1143 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Heb Sholom	May 7 1922
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad Ave

N. B.—WRITE LEGIBLY, with permanent ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64073 D 64073

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3823 Park Heights St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Jones

(a) RESIDENCE. No. 3823 Park Heights St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wolf Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Norman Lowenburg
(Address) 3823 Park Heights

15 MAY 7 - 1922 ROBERT R. KRAUTER, Registrar
Assist. Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 19 1917, to May 6, 1922, that I last saw her alive on May 5, 1922, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cecum

(duration) 2 yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) Renal carcinomatosis

(duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Masses, cachexia, Blood

(Signed) Chas C. Judd, M. D.

. 19 (Address) 1701 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL May 8 1922

20 UNDERTAKER Ahrens & Co — ADDRESS 1611 Madison Ave

N. B.—Entire information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64074 D 64074

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 E. Eager St.; 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen E. Klein

(a) RESIDENCE. No. 2002 E. Eager St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 2nd 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	4	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John T. Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Gilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John T. Klein
(Address) 2002 E. Eager St

15 MAY 7 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922 to May 6, 1922, that I last saw her alive on May 5, 1922, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T. Avery, M. D.

, 19 (Address) 1603 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: May 7 1922

20 UNDERTAKER: Geo M. Fritz & Son — ADDRESS: 844 N Wolfe

D 64075

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

101 D 64075

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 Edmondson Av. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. H. Down

(Residence in Baltimore: No. 3002 Edmondson Av St.; 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Nov (Month) 16 (Day), 1840 (Year)

7-AGE: 82 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE (State or country): West Virginia

PARENTS

10-NAME OF FATHER: David L. Down

11-BIRTHPLACE OF FATHER (State or country): West Virginia

12-MAIDEN NAME OF MOTHER: Mary Sudnick

13-BIRTHPLACE OF MOTHER (State or country): West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Schaffer

(Address) 3002 Edmondson Av

Filed MAY 7 - 1922, 19..

ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 5 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922 to May 5 1922, that I saw h.... alive on May 5 1922, and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Edema of Lungs

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank V. Dietz M. D.

May 6, 1922 [Address] 2838 Edmondson

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet

DATE OF BURIAL: May 8, 1922

20-UNDERTAKER: John Fields

ADDRESS: 1200 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64076

CERTIFICATE OF DEATH.

179 D 64076

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Hartman

(Residence in Baltimore: No. 110 No Eldwood Ave. St.; 54 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 6 (Day) 1845 (Year)

7-AGE, 76 yrs. 11 mos. 2 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Charles Hartmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Joanna Fortenbaugh

(Address) 110 N. Eldwood Ave

15- Filed MAY 7 - 1922 191..... ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 5 (Day) 4 (Year) 1922

17- I HEREBY CERTIFY, That I attended deceased from April 17 1922, to May 4 1922, that I saw h- alive on May 4 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) Unknown yrs. mos. ds.

(Signed) Herman J. Dorf M. D.

5/7, 1922 (Address) St. Joseph Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Hoan't Cem — DATE OF BURIAL, May 8, 1922

20-UNDERTAKER Jos C. Miller — ADDRESS 2334 Jeffers St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH must be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64077

CERTIFICATE OF DEATH.

98

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1153 Ridgely ST., 71 WARD)

2-FULL NAME John Real

(a) RESIDENCE NO. 1153 Ridgely ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) March 1 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	57	2	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Resteraunt

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Louis Real

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Andrew Real 1128 Ridgely St

15 MAY 7 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 5, 1922, that I last saw him alive on May 5, 1922, and that death occurred, on the date stated above, at 2 50 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic arthritis Rheumatic

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinic

(Signed) R Morley Strong, M. D.

6/4, 1922 (Address) 729 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 8 1922

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca St

Information should be carefully supplied. AGE should be stated EXACTLY. If LESS than one day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64078

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 S High ST. 3 WARD)

2-FULL NAME Teresa Lavezza

(a) RESIDENCE NO. 405 S High ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Natale Lavezza

6 DATE OF BIRTH (month, day, and year): May 1849

7 AGE — Years: 73 | Months: | Days: 4 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House keeping

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Domenic Fondola

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Fondola

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Catherine Bottia

(Address): 401 S High

15 MAY 7-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 5, 1922, that I last saw h[illegible] alive on May 5, 1922, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

May 7, 1922 (Address) 820 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent

DATE OF BURIAL: May 9 19 22

20 UNDERTAKER: Wendel Bynelson

ADDRESS: 375 Main

N. B.—WHITE [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64079

CERTIFICATE OF DEATH.

23

D 64079

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Nth Fulton Ave. ST., 15 WARD)

2-FULL NAME Carlyle Ansbury Caury

(a) RESIDENCE NO. 2125 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13th 1902

7 AGE: Years 19 Months 11 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Packers

(c) Name of employer Swift & Co

9 BIRTHPLACE (city or town) (State or country) Woodstock Maryland

PARENTS

10 NAME OF FATHER George W. Caury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Maryland

12 MAIDEN NAME OF MOTHER Francis M. Zepp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Maryland

14 Informant Miss Catherine Zepp

(Address) 21 North Carey St. Balto.

15 MAY 7 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to May 6th, 1922, that I last saw h alive on May 6th, 1922, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elbert C. Reitz M. D.

5/6, 1922 (Address) 2735 Penna. Ave Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MX Oliv Roslyn

DATE OF BURIAL: 5/9 1922

20 UNDERTAKER: William Cook

ADDRESS: 502 E Val

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64080

CERTIFICATE OF DEATH

D. 64080

1-PLACE OF DEATH Balto. General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 27 WARD)

2-FULL NAME Dorothy Louise Crouse

(a) RESIDENCE NO. 134 Rockwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1, 1921

7 AGE Years	Months	Days	11 LESS than 1 day, ... hrs. or ..... min.
1	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel F. Crouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Genevie Haupt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Samuel Crouse

(Address) 134 Rockwood Ave

15 MAY 7 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922, to May 5, 1922, that I last saw her alive on May 5, 1922, and that death occurred, on the date stated above, at 11 16 A. m.

The CAUSE OF DEATH* was as follows:

Traumatic Cerebral Hemorrhage

Accidental fall from a couch

No Inquest necessary. Otto M. Reinhardt M.D. Coroner

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic meningitis (?)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Earl F. Benson, M. D.

, 19 (Address) Balto. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL May 8 1922

20 UNDERTAKER Wm Cook — ADDRESS 848 Mt.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-002

D 64081

CERTIFICATE OF DEATH.

D 64081

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Raspeburg Md ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Marrille Merrell

(Residence in Baltimore: No. Ridge Croft Road St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, Single MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Mar (Month) 13 (Day), 1922 (Year)

7-AGE, ...yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Raspeburg Md

PARENTS.

10-NAME OF FATHER, Albert Merrill

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Carrie E. Corrigan

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Merrill

(Address) Raspeburg Md.

15- Filed MAY 7 - 1922, 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 5 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 13 1922 to May 5 1922 that I saw h.er alive on May 5 1922 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

Since (Duration) ....yrs. 1 mos. 23 ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) ....yrs. 1 mos. ....ds.

(Signed) Frank S. Smedley, M. D.

....., 191... (Address) 2512 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Parkwood — DATE OF BURIAL, 5/8, 1922

20-UNDERTAKER William Cook — ADDRESS 502 E North

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 64082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64082

31

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1570 Eastern Ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Antonio Casizzo

(Residence in Baltimore: No. 1570 Eastern Ave (22 yrs) St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 55 yrs yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): 514

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Casizzo

(Address) 1510 Eastern Ave

15- Filed MAY 7 - 1922, 19... ROBERT R. KRAUTER, Burial Permit Clerk; Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Fortson M. D. (Coroner)

May 6 1922 (Address) Curtis Bay Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents — DATE OF BURIAL, 5/6, 1922

20-UNDERTAKER William Cook — ADDRESS 502 E North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64083

CERTIFICATE OF DEATH.

179 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Russell

(a) RESIDENCE. (Usual place of abode) No. 3 Mowis ST.: Arlington WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Clara Russell

6 DATE OF BIRTH (month, day, and year) Dec 9 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER James Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Mary Stockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Mercy Hospital Records (Address)

15 Filed MAY 7 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 28 1922 to May 6 1922 that I last saw him alive on May 6 1922 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis Uremia

(duration) 2 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs Symptoms

(Signed) John J. Ervin, M. D.

19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 5/9 22

20 UNDERTAKER Woodlawn Cook

ADDRESS 502 E Nora

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64084 D

CERTIFICATE OF DEATH

REGISTERED No. C 45 D 64084

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1333 N. Caroline St. ST.; 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Howard Dunn

(Residence in Baltimore: No. 1333 Caroline St.; 64 yrs. 6 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH October 16, 1857 (Month) (Day) (Year)

7. AGE 64 yrs. 6 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) Baltimore, Maryland

PARENTS

10. NAME OF FATHER Thomas Wolf

11. BIRTHPLACE OF FATHER (State or country) Ireland

12. MAIDEN NAME OF MOTHER Ellen Murphy

13. BIRTHPLACE OF MOTHER (State or country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William M. Dunn

(Address) 1333 N. Caroline St.

Filed May 7 - 1922, 191 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about 1 year ago, 191 , to May 4 1922

that I saw h alive on May 4 , 1922

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cancer Rectum

1 year (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

May 6, 1922 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/8, 191 22

20. UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT CITY OF BALTIMORE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64085

15-3 D 64085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 N. Gilmor ST., 16 WARD)

2-FULL NAME Adolph Pick

(a) RESIDENCE NO. 903 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Pick

6 DATE OF BIRTH (month, day, and year) Aug 1 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Edward Pick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Laura Drenker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Friend Edward Pick

(Address) 903 N Gilmor St.

15 MAY 7 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 1922, to May 6, 1922, that I last saw him alive on May 6, 1922, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope about 6 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Intramural Fibroid Uterus

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No. Date of ——

Was there an autopsy? No.

What test confirmed diagnosis? ——

(Signed) G. Lobster Ewalt, M. D.

5/6 1922 (Address) 905 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL May 8 1922

UNDERTAKER Wm. J. Gickner & Son

ADDRESS N. Pa

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64086

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH 4th Ave & 6th St Fairfield 25 12

CITY OF BALTIMORE: (No.) Fairfield ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Donnelly

(Residence in Baltimore: No. Fairfield Ave ST.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1879
(Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Horseshoer
(b) General nature of industry, business, or establishment in which employed (or employer): DH5

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Donnelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Lorimer

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Donnelly

(Address) Fairfield Md

15- Filed MAY 7 - 1922 19... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 26 1922, to May 5 1922, that I saw h[e] alive on May 5 1922, and that death occurred, on the date stated above, at 5-45 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. ds.

(Signed) Chas. Barton M. D.

May 7, 1922 (Address) Brooklyn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross DC — DATE OF BURIAL, May 8, 1922

20-UNDERTAKER Potts & Blakistone — ADDRESS 1111 Eighth

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64087

90 64087

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillsdale, Baltimore St. Md. 28 WARD)

2-FULL NAME Edward Reid Pierce

(a) RESIDENCE NO. Forest Park Ave. Hillsdale, Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 13" 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hillsdale Md.

PARENTS

10 NAME OF FATHER Ira E. Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hillsdale Md.

12 MAIDEN NAME OF MOTHER Elsie Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Minneapolis

14 Informant Mrs. E. Pierce (Address) Hillsdale, Md.

15 MAY 7-1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5" 19 22

17

I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1919, to May 5th, 1922

that I last saw h alive on May 4th, 1922

and that death occurred, on the date stated above, at 3.20 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & Aortic Regurgitation

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Emmert M. D.

May 5" 1922 (Address) 4209 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL May 8" 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto

50

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. The primary CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

64088 D 64033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

64088 D 64088

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Cor Forrest & Chas St. 10 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sr Bernadine Waite

(Residence in Baltimore: No 11 Frances Convent St.; 6 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. 12 (Month) – 9 (Day), 1898 (Year)

7-AGE. 23 yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): R.C.

9-BIRTHPLACE, (State or Country), Trinidad, British West Indies

PARENTS.

10-NAME OF FATHER, Hugo Waite

11-BIRTHPLACE OF FATHER (State or Country), Trinidad B. W. I.

12-MAIDEN NAME OF MOTHER Marie Gorgrie

13-BIRTHPLACE OF MOTHER (State or Country), Trinidad B. W. I.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother M. Frances O.S.P.

(Address) St. Frances Convent E. Chas St

15- MAY 7 - 1922 Filed ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 5 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1921, to May 1922, that I saw h[er] alive on May 1 1922, and that death occurred, on the date stated above, at 10.45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 9 mos. ds.

(Signed) Mary F. Voegtlen M. D.

May 5, 1922 (Address) 10.28 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, May 8, 1922

20-UNDERTAKER Felix B. Pyz

ADDRESS 2 E Madison St

N. B.—Every item of information must be given as accurately as possible, as this certificate is legally classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64089

CERTIFICATE OF DEATH.

179 D 64089

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Md General Hosp ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lee Swann

(Residence in Baltimore: No. 1724 Carswell St.; 8 yrs., mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, April 25th, 1914
(Month) (Day) (Year)

7-AGE, 8 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph L. Swann

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mamie Brockenbrough

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph L. Swann

(Address) 1724 Carswell St.

15- Filed MAY 8 - 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, jury find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

2nd & 3rd degree burns of body

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) playing with fire

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

May 7, 1922 (Address) 280 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1724 Carswell St.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, May 8th, 1922

20-UNDERTAKER Mr. & Mrs. John H. Teufel Son ADDRESS 844 S. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particularly careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64090

CERTIFICATE OF DEATH.

3 | D 64090

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Municipal Tb Hospital

CITY OF BALTIMORE: (No. ..... ST.: 13 WARD)

2-FULL NAME Edward Rayner

(a) RESIDENCE. No. 2604 Bruce Terrace ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Employment Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. Rayner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Un Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) John A. Rayner 2604 Bruce Terrace

15 MAY 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to May 6, 1922, that I last saw him alive on May 6, 1922, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. not known mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) yrs. not kno. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum examination.

(Signed) Francis L. Dadaglicca M. D.

. 19 (Address) Municipal Tb Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	May 8 1922

20 UNDERTAKER John J. Fields ADDRESS 1200 N Fremont

INFORMATION should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burnett

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64091

CERTIFICATE OF DEATH.

702

D 64091

REGISTERED NO. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Burnett

(Residence in Baltimore: No. 1726 Druallwood al— St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 2, 1904
(Month) (Day) (Year)

7-AGE, 8 months
yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nom 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, John Burnette

11-BIRTHPLACE OF FATHER (State or Country). Balto md

12-MAIDEN NAME OF MOTHER Catharine Lever

13-BIRTHPLACE OF MOTHER (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Burnett

(Address) 1726 N. Smallwood

15- FILED MAY 8 - 1922 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidently foreign body in trachea. Died from shock.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probably accidentally swallowed a button

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Young M. D.
(Coroner.)

5-6, 1922 (Address) 117 N. Smallwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State .... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, May 8, 1922

20-UNDERTAKER Wm Cook — ADDRESS N. & S. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

Wolcott

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64092

CERTIFICATE OF DEATH.

46

D 64092

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Mount Pleasant ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Sarah Wolcott

(a) RESIDENCE NO. 1615 Mount Pleasant ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edwin H. Wolcott

6 DATE OF BIRTH (month, day, and year): Jan 10 1871

7 AGE: Years 51 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Thomas Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Rebecca Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs. Edwin H. Wolcott

(Address): 1615 Mount Pleasant Ave

15 Filed MAY 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1921, to May 4, 1922.

that I last saw h[er] alive on May 4, 1922

and that death occurred, on the date stated above, at 9-40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ruth S Kinsey, M. D.

5/6, 1922 (Address) 2700 Hoffman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid. Gdns

DATE OF BURIAL: May 8 1922

20 UNDERTAKER: H. M. Cook

ADDRESS: H & Mc

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64093

CERTIFICATE OF DEATH.

D 64093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 E. Franklin ST.; 4 WARD)

2-FULL NAME Annie E. Williams

(a) RESIDENCE. No. 107 E Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Williams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fairfax Co Virginia

PARENTS

10 NAME OF FATHER Frank Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Josephine Gibbs (Address) 1072 E. Franklin St.

15 Filed MAY 8 - 1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1922, to May 5th, 1922, that I last saw h.e alive on May 6th, 1922, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) I Bunnell Fargo, M. D.

, 19 (Address) 746 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 8 1922
20 UNDERTAKER	ADDRESS 142 Ostend St
John H. Fradum	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64094 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 647 Josephine ST.; 4 WARD)

2-FULL NAME Lucille Page

(a) RESIDENCE. NO. 647 Josephine ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs mos. ds

REGISTERED NO. 12D 64094

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nicholas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John McClure
(Address) (647 Josephine St.

15 Filed MAY 8 - 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6/ 19 22

17 I HEREBY CERTIFY, That I attended deceased from 5/5/ 19 22, to 5/6/ 19 22,
that I last saw her alive on 5/6/ 19 22,
and that death occurred, on the date stated above, at 10:25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion, (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Errors in diet, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) R. Lee Sparley, M. D.

5/6/ 19 22 (Address) 908 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 9 1922
20 UNDERTAKER	ADDRESS 142
John H. Toadvine	Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64095 D 64095

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. First & North Ave ST. E. Washington WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean L. Bandel

(a) RESIDENCE. No. First & North Ave ST. Washington WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25, 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Norman R. Bandel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Jennie Starr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr. Norman R. Bandel
(Address) First & North Ave Est Wash

15 Filed MAY 8 - 1922 ROBERT F. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1922, to May 6, 1922, that I last saw h alive on May 5, 1922, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia due to failure of closing of foramen ovale

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at birth

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. H. Bleeten, M. D.

5.6, 1922 (Address) 1101 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary Govans	May 9 1922
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEFINITION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64096

CERTIFICATE OF DEATH.

91-002 D 64096

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S. Paca ST., 21 WARD)

2-FULL NAME Francis P. Skelchion

(a) RESIDENCE NO. 818 S. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Elizabeth Skelchion

6 DATE OF BIRTH (month, day, and year) Sept 15 1841

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	80	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preserver

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Swensen & Sons

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER — Skelchion

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Kaudner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Harry Skelchion
(Address) 818 S. Paca St

15 MAY 8 - 1922 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 6 1922

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1922, to May 6, 1922,

that I last saw him alive on May 6, 1922,

and that death occurred, on the date stated above, at 4 0, m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) ans. yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lumperin, M. D.

May 9 1922 (Address) 826 E. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL MAY 9 1922

20 UNDERTAKER Geo W Little

ADDRESS 2700 E Monument Ave

mation should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

155714. D 64097.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003 D 64097.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " St., 19 WARD)

2-FULL NAME John Larkin.

(a) RESIDENCE No. 425 N. Biddle St. City

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ John Larkin (father)

6 DATE OF BIRTH (month, day, and year) Feb. 9, 1922.

7 AGE: Years — Months 2 — Days 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, nfd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER John Larkin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Woolford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Same

15 MAY 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5 1922 to May 6 1922 that I last saw him alive on May 6 1922 and that death occurred, on the date stated above, at 2.00 A. m.

The CAUSE OF DEATH* was as follows:

Congenita Cystic Kidney

Died (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. B. Gay M. D.

1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL May 8 1922

20 UNDERTAKER Jno. M. Johnson — ADDRESS 1234 Eutaw St.

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64098

D 64098

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 N. Pat. Pk. Av ST., 7 WARD)

2-FULL NAME Maud Leverton

(a) RESIDENCE NO. 826 N. Pat. Pk. Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Lieut James M. Leverton

6 DATE OF BIRTH (month, day, and year) Dec 10 - 73

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4	25	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Thos. Schackelford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lieut James M. Leverton

(Address) 826 N. Pat. Pk Av

15 Filed MAY 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1922

17 I HEREBY CERTIFY, That I attended deceased from about Aug. 1921 to May 5 1922

that I last saw h~~er~~ alive on May 5 1922

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

one (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Novak, M. D.

, 19 (Address) 821 N. Pat. Pk. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL May 8 1922

20 UNDERTAKER Philip Herrig ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Delahay.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64099

100-001

CERTIFICATE OF DEATH.

D 64099

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE, NO. ..... ST. 22 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Delahay

(a) RESIDENCE NO. 5113 Wilson Ave. ST., Arlington
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan

6 DATE OF BIRTH (month, day, and year): 1837

7 AGE — Years: 85. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Edward Delahay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Bayview Hosp.
(Address): Baltimore, Md.

15 Filed MAY 8 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to May 5, 1922
that I last saw h[illegible] alive on May 5, 1922
and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. F. Edmunds M. D.

5/6, 1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 8 1922

20 UNDERTAKER: Solon Holloway & Son — ADDRESS: for Holloway 57

mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64100

CERTIFICATE OF DEATH.

185

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bay View Asylum ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Moran

(Residence in Baltimore: No. 50 yrs 1529 Shirley Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 25th (Day), 1870 (Year)

7-AGE, 51 yrs. 4 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Wm Moran

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Annie Gannon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Thos Spicer (Sister)

(Address) 1529 Shirley Ave

15- MAY 8 - 1922 191. ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry), thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) yrs. mos. 20 hrs

CONTRIBUTORY (Secondary) Fell down steps

(Duration) yrs. mos. ds.

(Signed) Thos B Horton M. D.
(Coroner)

May 7th 1922 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from violent causes state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cem. DATE OF BURIAL, May 9, 1922

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S Wolfe

N.B.—Every item of information should be carefully supplied. AGE should be stated in years and months. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64101

CERTIFICATE OF DEATH.

1001 1745 64101

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Gold ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Harper

(Residence in Baltimore: No. 404 Gold St.; 50 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) ..... (Year)

7-AGE, 51 yrs. ~ mos. ~ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): D 37

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Washington Brown

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Cobby

(Address) 404 Gold St

15- Filed MAY 8 - 1922 191..... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6th 1922, to May 6" 1922, that I saw her alive on May 6" 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Six hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Convulsions A few minutes

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. B. Glass M. D.

May 7th, 1922 (Address) 1812 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, May 9, 1922

20-UNDERTAKER James A. Deans — ADDRESS 1303 Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64102 ✓ D 64102

38

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 11 WARD)

2-FULL NAME Charles Grimmel

(a) RESIDENCE. NO. 207 West Biddle ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mercy Hospital Records (Address)

15 Filed MAY 8 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 30 1922 to May 3 1922

that I last saw him alive on May 3 1922

and that death occurred, on the date stated above, at 5:05 P. m.

The CAUSE OF DEATH* was as follows:

Tertiary Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Leuto meningitis and Dementia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings at autopsy and clinical signs

(Signed) John J Erwin M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	May 8 1922
20 UNDERTAKER James H. Dennis	ADDRESS 1703 Guilford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64103

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 239 N Gilmore St. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Roberts

(a) RESIDENCE. No. 239 N Gilmore St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Roberts

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rectifier 08

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: J. Ullman & Son

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Richard Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Margaret Roberts
(Address) 239 N Gilmore St

15 Filed MAY 8 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 6, 1922, that I last saw him alive on May 4, 1922 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Cardiac paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

19 (Address) 904 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 5/9 1922

20 UNDERTAKER: Martin Funeral Home

ADDRESS: 1827 N North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64104

CERTIFICATE OF DEATH.

155 D 64104

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 70 WARD)

2-FULL NAME Mrs Mable Medlin

(a) RESIDENCE NO. 223 S. Pulaski ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed. J. Medlin

6 DATE OF BIRTH (month, day, and year) Oct. 4-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. A Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret J. Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Edward J. Medlin

(Address) 223 S. Pulaski St.

15 Filed MAY 8- 1922 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 — 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-3-22, 19..., to 5-5-22, 19 22.

that I last saw h.. alive on 5-5-22, 19 .....

and that death occurred, on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH* was as follows:

Basilar Meningitis

Secondary to Par-sinusitis and Ophthalmitis right (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pyelitis (duration) 7 mos. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-4-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Browns Object	May 8 1922
20 UNDERTAKER	ADDRESS
George Lehmab	2101 Fudk. Ave

mation should be carefully supplied. AGE should be stated in every case. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64105

CERTIFICATE OF DEATH.

9 1 D 64105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 Richmond St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Breen

(a) RESIDENCE. NO. 234 Richmond ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Wht	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Breen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coachman

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer Alex Brown

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Breen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McGraw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Breen (Address) 234 Richmond St

15 Filed MAY 8 - 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6 1922

17 I HEREBY CERTIFY, That I attended deceased from 2/6, 19 22, to 5/6, 19 22, that I last saw h alive on 5/6, 19 22, and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George L. Duane M. D.

, 19 (Address) 721 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	5/9 1922
20 UNDERTAKER	ADDRESS
Martin Hafey Co	1827 W Mont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Bradford

D 64106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64106

CERTIFICATE OF DEATH.

Registered No. C 181

1-PLACE OF DEATH

City of BALTIMORE: (No. 817 Washington Boulevard Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eileen Bradford

(Residence in Baltimore: No. 817 Washington Boulevard St.; yrs. 1/2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	single

6-DATE OF BIRTH. Dec 30 1921
(Month) (Day) (Year)

7-AGE. 0 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of Industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Hubbard Bradford

11-BIRTHPLACE OF FATHER. (State or Country). South Carolina

12-MAIDEN NAME OF MOTHER. Eulelae Stinnett

13-BIRTHPLACE OF MOTHER, (State or Country). South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eulelie Bradford

(Address) 817 Washington Boulevard

15-

Filed MAY 8-1922 192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration when the tractors ran over her head

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H Preston M. D.
(Coroner.)

May 8 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park — DATE OF BURIAL. May 9 1922

20-UNDERTAKER. Wm Cook — ADDRESS 1st & Hill

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64107

D 64107

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 502 Beaumont Ave. (St.:) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sullivan

(a) RESIDENCE. No. 502 Beaumont Ave. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sullivan

6 DATE OF BIRTH (month, day, and year) Dec. 20th. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Agnes Klug (Address) 502 Beaumont Ave.

15 Filed MAY 8 - 1922 S. E. Mehrs Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1919, to May 6, 1922, that I last saw him alive on May 6, 1922, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Koons, M. D.

5/6, 1922 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/9/22

ADDRESS

UNDERTAKER C. F. Evans & Son—118 W. Mt Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64108

D 64108

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 So. Eden ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Williams

(a) RESIDENCE. NO. 34 So. Eden ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3. 1922.

7 AGE Years Months Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Williams

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Helena Rudolf

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Edward Williams (Address) 34 S Eden St

15 Filed MAY 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1922, to May 8th, 1922, that I last saw h-e alive on May 6th, 1922, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth under weight, and general weakness.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Saml Snyder, M. D.

, 19 (Address) 38 S Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents Cem DATE OF BURIAL May 8, 1922

20 UNDERTAKER Wendell Hoppe (rep. by E. J. Hand) ADDRESS

(Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D 64109 HEALTH DEPARTMENT—CITY OF BALTIMORE 001

V 74

CERTIFICATE OF DEATH.

D 64109

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Hoet ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Piszak

(Residence in Baltimore: No. 1909 Hoet St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not known (Month) (Day) 1 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Mathew Piszak

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wagner

(Address) 518 S. Durham

15- Filed MAY 8 1922 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from April 16 1922, to May 6 1922, that I saw h— alive on May 6 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(Duration) yrs. mos. 1 ds.

(Signed) William Hyssek M. D.

May 7, 1922 (Address) 518 N. Green

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, May 9, 1922.

20-UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St.

N. B.—Every item of information must be given, so that it may be properly classified. Last statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Maggie Chase V

143-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64110 REGISTERED NO. D 64110

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Whetstone ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Chase

(a) RESIDENCE. NO. 1207 Whetstone ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Chase

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 30 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ann Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Lillie Jones 1207 Whetstone

15 Filed MAY 8 - 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/8 19 22

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 19 22, to 5/8, 19 22, that I last saw h— alive on 5/4, 19 22, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Ac Pleurisy
+ Congestion of Lungs
Duration 4/21 22

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhitt, M. D.

, 19 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: May 8 1922

20 UNDERTAKER: Edward Quigold — ADDRESS: 1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64113

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Smith

(a) RESIDENCE NO. 1106 Riggs Ave. St., ... Ward .....
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Dennis Smith

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 40 yrs	?	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed MAY 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1922

17 I HEREBY CERTIFY, That I attended deceased from May, 19.. to May 6th, 1922, that I last saw her alive on May 6th, 1922, and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Myomata Uteri.
Pelvic Cyst adenoma ovarii
Pelvic Peritonitis

(duration) ..... yrs. ..... mos 25 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? yes Date of 5/4/22

Was there an autopsy? yes.

What test confirmed diagnosis? Operative Observation

(Signed) George H. Gardner, M. D.

19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mathews Co., Va. Creaker Hill Mem.

DATE OF BURIAL May 8 1922

20 UNDERTAKER Edward Praggold

ADDRESS 1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Gonococcus Infection

Spec.—6-9-19—H. P. Co.—1000 Bks.

Blocker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64112

CERTIFICATE OF DEATH.

100-61

D 64112

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Warner St. (ST.) Mt. Winans (WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Corrie Blocker

(a) RESIDENCE. (No.) Warner St. (ST.) Mt. Winans WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE S

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14, 1920

7 AGE Years 1 Months 11 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Blocker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Columbia, S. C.

12 MAIDEN NAME OF MOTHER Sarah Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn, Md

14 Informant Wm Blocker (Address) Mt. Winans

15 Filed MAY 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/1922

17 I HEREBY CERTIFY, That I attended deceased from 4/27/, 1922, to 5/16/, 1922, that I last saw h[illegible] alive on 5/5/, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: OVER

Broncho-Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. B. Stanton, M. D.

5/16, 1922 (Address) 1216 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL May 8 1922

20 UNDERTAKER Thos. Gerst & Son ADDRESS 406 W Conway

Information should be carefully examined, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Spec.--1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64113

CERTIFICATE OF DEATH.

D 64113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 E Oliver ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Robert Rehberger

(a) RESIDENCE NO. 2209 E Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Edward A Rehberger

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Meyers

13 BIRTHPLACE OF MOTHER (city or town) Bridgeton (State or country) N.J.

14 Informant Edward A. Rehberger

(Address) 2209 E. Oliver St

15 MAY 8—1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to May 7, 1922, that I last saw him alive on May 7, 1922, and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical manifestation

(Signed) Daniel Miller, M. D.

, 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 9th 1922

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Oliver St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE of DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64114

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001
161-D 64114

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Call St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna May Brown

(Residence in Baltimore: No. 1604 Eale St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 7 (Day), 1922 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or 1 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

000

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Raymond C. Brown

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co. Md

12-MAIDEN NAME OF MOTHER, Lucy V. Shaner

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Linley Brown

(Address) 1604 Eale St

15- Filed MAY 8 1922, 191.. J. C. Helm Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5/7 1922, to 5/7 1922, that I saw h[illegible] alive on 5/7 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity Infant

9 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Culver Jones M. D.

5/8, 1922 (Address) 1901 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Cemty, Hampden

DATE OF BURIAL, May 8, 1922

20-UNDERTAKER, Harry A. Witz & Co

ADDRESS 1531 W Lombard St

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Use no abbreviations. Every item important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 64115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64115

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Orleans ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Harold Katz

(a) RESIDENCE NO. 1520 Orleans ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 10-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Harry Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ethel Ringler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Harry Katz (Address) 1520 Orleans st

15 Filed MAY 8 1922 19..... J. E. Webster Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10 1922 to May 8 1922, that I last saw him alive on May 7 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ..... yrs. mos 28 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Edward J. Levi M. D.

5/8, 1922 (Address) 413 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 8 1922
20 UNDERTAKER	ADDRESS
Thos. L. Miller	2334 Jefferson

MARK should be distinct, legible. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D 64116 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64116

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Webster

(a) RESIDENCE NO. 113 Colvin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 048

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Baker Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed 8-1922, 19 Robert P. Harrison, Registrar Burial Permit Clerk?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1922

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1922 to May 3, 1922, that I last saw him alive on May 3, 1922, and that death occurred, on the date stated above, at 7:25 P.M.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortic insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

5/4/1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 1922

20 UNDERTAKER Commissioner Health.

ADDRESS

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very imprtant. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 64117

CERTIFICATE OF DEATH

100.001 ✓

D 64117

1 PLACE OF DEATH

Registered No. C .....

City of Baltimore (No. St. Elizabeth's Home St.; 9 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frederick Black

(Residence in Baltimore: No. St. Elizabeth's Home St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: Nov. 27th (Month) (Day), 1920 (Year)

7 AGE: 1 yrs. 5 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Bardswell

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Corinne Black

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Home Records

(Address) .....

15. Robert P. Harrison, ...

....., 191.....

REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 7 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December, 1921, to May 7 1922,

that I saw him alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Rickets

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed), Frank J Ayd M. D.

May 7, 1922 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. 11 mos. 25 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: ....., 191.....

20 UNDERTAKER: .....

ADDRESS: .....

Commissioner of Health.

per Wm. S. McCall.

1922

MAY 8 - 1922

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 64118

CERTIFICATE OF DEATH

D 64118

Registered No. C 90

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 403 Spalding Ave St. 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Stephen M. Miller

(Residence in Baltimore: No. 403 Spalding Ave St.: 73 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Aug 5, 1843 (Month) (Day) (Year)

7 AGE: 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 1909

9 BIRTHPLACE (State or country): Glasgow Scotland

PARENTS

10 NAME OF FATHER: Stephen M. Miller

11 BIRTHPLACE OF FATHER (State or country): Glasgow Scotland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (State or country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard M. Miller

(Address) 2212 James St Norwood Pk

15 May 8 1922 Robert P. Harrison, 191 REGISTRAR

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 7 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1922 to May 6 1922 that I saw h[illegible]live on May 6, 1922 and that death occurred, on the date stated above, at 8 4 m.

The CAUSE OF DEATH* was as follows:

General arterio Sclerosis and Myocarditis

(Duration) yrs. 5 mos. ds

Contributory (SECONDARY) Cerebral Hemiplegia

(Duration) yrs. mos. 1 ds.

(Signed) Stanley McCabe M. D.

May 8, 1922 (Address) 1609 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: May 9, 1922

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

(Sweeney)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64119

D 64119

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Rooney

(a) RESIDENCE NO. Epiphany College ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Chas Rooney (Address) Epiphany College

15 Filed 8 1922, 19 Robert F. Murphy, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-6, 1922, to 5-7, 1922, that I last saw him alive on 5-7, 1922 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforation peritonitis

(duration) 6 hrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/7/21

Was there an autopsy? Yes

What test confirmed diagnosis? Biopsy at operation

(Signed) W. W. Scott M.D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL May 9 1922

20 UNDERTAKER William Cook ADDRESS 5 & E North Ave

mation should be entered, supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64120

CERTIFICATE OF DEATH.

129 D 64120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 758 Waverly ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Haywood

(Residence in Baltimore: No. 758 Waverly St.; 47 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1862
(Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. D. Haywood

(Address) 758 Waverly

15-

Filed ....Robert P. Harrison, 191.....
Registrar.

8-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 1 1922, to May 7 1922, that I saw h er alive on May 6 1922, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis with Arterio Sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. 2 mos. 10 ds.

(Signed) W. P. Hughes M. D.

5/8, 1922 (Address) 637 Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem

DATE OF BURIAL, May 10 1922

20-UNDERTAKER David Carter

ADDRESS 916 E Pratt

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64121

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N Harris St. ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Johnson

(a) RESIDENCE NO. 505 N Harris ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther W. Johnson

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not employed

9 BIRTHPLACE (city or town) (State or country) Accomac Co Va

PARENTS

10 NAME OF FATHER Geo. Gamon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac

14 Informant Luther W. Johnson

(Address) 505 N. Harris St.

Filed ..... 19 .....

Registrar

Robert T. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 7, 1922, that I last saw h.. alive on May 7, 1922, and that death occurred, on the date stated above, at 12 Nm.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical Exam

(Signed) W. Gilles Forbes M. D.

, 19 (Address) 9618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL May 11 1922

20 UNDERTAKER David Foster

ADDRESS 916 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE or CONDITION is very important. See instructions on back of certificates.

D 64122 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64122

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 730 Pennsylvania Ave St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. H. Green

(Residence in Baltimore: No. 730 Pennsylvania Ave. St. 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: About (Month) (Day) 1881 (Year)

7-AGE: 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer (40)
(b) General nature of Industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country): Dont Know

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lucia Green

(Address) 730 Penna. Ave.

15-

Filed MAY 8 1922 192

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) Jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia

following abscessed tooth

(Contracted) (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. Hennessy M. D. (Coroner.)

May 8 1922 (Address) 230 E. Lanvale Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ce DATE OF BURIAL, May 10 1922

20-UNDERTAKER, David Easton & Co ADDRESS 916

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64123 D 64123

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH U.S.V.HOSP.#56, REGISTERED NO.....

CITY OF BALTIMORE: (No. Ft.Mc Henry,Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J.O'Brien, Ft.McHenry,Md.

(a) RESIDENCE NO. U.S.Veterans' Hosp.#56, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred L yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxxxx

6 DATE OF BIRTH (month, day, and year) May 30/1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,Md. (State or country)

PARENTS

10 NAME OF FATHER William O'Brien

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Emily Avery

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Hospital records, (Address) Ft. McHenry, Md.

15 Filed MAY 8 1922 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1922, to May 5, 1922.

that I last saw him alive on May 5, 1922,

and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis, far advanced and active

---- (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ----

--- (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clin.&Lab.

(Signed) M D Fitz, M. D.

5/5 1922 (Address) Surgeon US. r.H.S. U.S.V.Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL May 8 1922

UNDERTAKER William Cook ADDRESS 502 E Nath Av

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PLACE OF OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64124

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 001

D 64124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N.Carrollton Ave. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Lee Sauner,

(a) RESIDENCE NO. 521 N.Carrollton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21.1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H.Sauner,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth A.Schley,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John H.Sauner,

(Address) 521 N.Carrollton Ave

15 Filed ....., 19 .....

Registrar

MAY 8-1922

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 8 1922

17

I HEREBY CERTIFY, That I attended deceased from August, 1921, to May 8th, 1922, that I last saw her alive on May 8th, 1922, and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Infectious Otitis Media (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Howard Dyckhark, M. D.

5/8/ 1922 (Address) 701 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 11 1922

20 UNDERTAKER Geo W Little

ADDRESS 2700 EdmondsonAve

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

No infectious disease prior to otitis media.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64125

D 64125

CERTIFICATE OF DEATH.

84

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 Stirling ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Innocence Alves.

(a) RESIDENCE. No. 614 Stirling ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov. 29 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook on Oil

(b) General nature of industry, business, or establishment in which employed (or employer) Boats.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cape De Verd. Por.

PARENTS

10 NAME OF FATHER Emanuel Alves.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cape De Verd.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Mollie Williams. (Address) Stirling

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MAY 8 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922, to May 7, 1922, that I last saw h... alive on May 4, 1922, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis,

Non-Malignant Tumor

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) G. Brain

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John P. Fell, M. D.

5/8, 19 22 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Laurel Cemetery	
20 UNDERTAKER Liston F. Funeral Dir.	ADDRESS 1620 E. Fayette

IMPORTANT. This certificate should be carefully supplied. AGE should be accurately stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 64126 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64126

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Susie C. Tiernan.

(Residence in Baltimore: No. 1819 Presstman St. St.; yrs. mos. ds.)

2.----------

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White.

5-Single, Married, Widowed or Divorced, (Write the word.): Married.

6-DATE OF BIRTH. August 27th. 1886. (Month) (Day) (Year)

7-AGE. 35 yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER, William Dudley.

11-BIRTHPLACE OF FATHER, (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER, Fannie Tompkins.

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Dudley.

(Address) 1819 Presstman St.

15- Robert P. Harrison,

Filed. 192.

Registrar.

8-1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 5th. 1922. (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull & Pelvis
Collision between street car & automobile Accidental Death

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

May 8th 22 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? at. Paul & 20th. st. May 4th. 1922.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Charlottesville Va DATE OF BURIAL. May 9th 1922

20-UNDERTAKER. Martin Haley & Sons ADDRESS 1827 W North Ave

3-state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

15 D 64127

HEALTH DEPARTMENT—CITY OF BALTIMORE

003

15 D 64127

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " St., " Ward 6)

2-FULL NAME Harold Golden.

(a) RESIDENCE NO. 18 N. Bond St. ST., City WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND of) (or) (WIFE of) Sarah Golden (mother)

6 DATE OF BIRTH (month, day, and year) April 8, 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. gpd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Martin Golden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Levin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records.

15 Filed MAY 9-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922, to May 8, 1922.

that I last saw him alive on May 8, 1922

and that death occurred, on the date stated above, at 2.00 A. m.

The CAUSE OF DEATH* was as follows:

Pyloric stenosis

(duration) 0 yrs. 0 mos 21 ds.

CONTRIBUTORY 0 (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at birth

Did an operation precede death? yes Date of 5-4-22

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) H. H. Wash M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 5/9 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

SECTION SHOULD BE CAREFULLY FILLED OUT. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.- 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64128

CERTIFICATE OF DEATH.

185 D 64128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Indiana ave ST., Wilfort 25 WARD)

2-FULL NAME Margaret Eyring

(a) RESIDENCE NO. 634 Indiana ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Eyring

6 DATE OF BIRTH (month, day, and year) Aug 11, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	71	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant: Mrs Lena Evans (Address) 634 Indiana ave.

15 MAY 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922 to May 6, 1922.

that I last saw h.. alive on May 5th, 1922.

and that death occurred, on the date stated above, at 1 PM. m.

The CAUSE OF DEATH* was as follows:

Fracture of Sternum (due to fall).
Accidental Fall (No Inquest necessary down stair way (Also Rheumatism no Contributory)
(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary) Old Age.
(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Chas Horsley, M. D.

5/8, 1922 (Address) 888 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL May 9, 1922

20 UNDERTAKER Wm Cook, 502 E North ave ADDRESS

Attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D-485-9

D 64129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64129

CERTIFICATE OF DEATH.

X 49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " a. Ft. ST., N WARD)

2-FULL NAME Col. Clement Flagler

(a) RESIDENCE NO. Albion Hotel ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 11 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Flagler

6 DATE OF BIRTH (month, day, and year) Aug. 17-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	54	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Army officer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Daniel Flagler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Decatur N. Y.

12 MAIDEN NAME OF MOTHER Mary Emiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Penn.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Record.

15 Date Received MAY 9-1922 Registrar ROBERT R. KRAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1922, to May 7th, 1922, that I last saw h[illegible] alive on May 7th, 1922, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

Metastasis to (?)

(duration) 2 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) General Exhaustion

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Apr. 3 - 22

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Cecil H Bagley M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Va DATE OF BURIAL May 10 1922

20 UNDERTAKER John C. Mitchell ADDRESS 1201 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64130

D 64130

CERTIFICATE OF DEATH.

REGISTERED NO. C 51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 N. Spring ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ignatius Kastner

(Residence in Baltimore: No. 1518 N. Spring St.; 24 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. (Month) 16 (Day), 1857 (Year)

7-AGE, 64 yrs. 4 mos. 21 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Varnisher
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Vienna, Austria

PARENTS.

10-NAME OF FATHER, Sebastian Kastner.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Theresa Kastner

(Address) 518 N. Spring St.

15- Filed MAY 9 - 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 7th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 22, 1922, to May 7th 1922, that I saw him alive on May 7th 1922, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) ....yrs. ....mos. 30 ds.

(Signed) E. J. Lebold M. D.

May 7th, 1922, (Address) 1001 Arlington Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery | DATE OF BURIAL, May 10, 1922

20-UNDERTAKER Henry Hauck & Son | ADDRESS 1301 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64131

D 64131

CERTIFICATE OF DEATH.

X 148

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Tamacha Griffin

(a) RESIDENCE NO. Rossville, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Griffin

11 BIRTHPLACE OF FATHER (city or town) Chase,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mable Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 FILED MAY 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 7, 1922,

that I last saw h e alive on May 7, 1922

and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Pregnancy, with a toplemia, apparently eclamptic, which came on shortly after delivery-

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Brumbach, M. D.

5/8/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stevens Back River

DATE OF BURIAL May 10 1922.

20 UNDERTAKER John W Henderson

ADDRESS 1002 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 15246 D 64132

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09

D 64132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. .. .. .. ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Thomas. H. City

(a) RESIDENCE NO. 1631 Williams ST., ... WARD ....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Louis Thomas (Father)

6 DATE OF BIRTH (month, day, and year) Dec. 1 - 1920

7 AGE: Years 1; Months 6; Days 7

If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER Louis Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Belle Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records

JOHNS HOPKINS HOSPITAL

15 MAY 9 - 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to May 7, 1922, that I last saw him alive on May 7, 1922, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute empyema left chest.

over

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia right lung

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes. Date of April 17, 1922

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) P B MacCready, M. D.

, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL May 10 1922

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Burial Permit Filed

Information should be carefully supplied. Any mistake or omission may cause delay. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-09 B 64133

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 918 Whatcoat ST. 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth A. Jones

(Residence in Baltimore: No. 918 Whatcoat St. St.; 1 yrs., mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	single

6-DATE OF BIRTH, April 6, 1921 (Month) (Day) (Year)

7-AGE, 1 yrs. mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer) (Duplex)

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, John Jones
11-BIRTHPLACE OF FATHER (State or Country), Md,
12-MAIDEN NAME OF MOTHER Mary Hawkins
13-BIRTHPLACE OF MOTHER (State or Country), Md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Jones
(Address) 918 Whatcoat St.

15- MAY 9 - 1922 191 ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to. her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)
May 8, 1922 (Address) 2802 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters
DATE OF BURIAL, May 9, 1922

20-UNDERTAKER Edward Ruggold ADDRESS 1463 Carey

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
CAUSE OF DEATH in plain terms.

Spec.—1-10-21—M&T—1500 Bks.

CLARA HUBBS

HEALTH DEPARTMENT—CITY OF BALTIMORE

1,001

D 64134

CERTIFICATE OF DEATH.

X 118 D 64134

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital ST., 19 WARD)

2-FULL NAME Clara Hubbs

(a) RESIDENCE NO. Owings Mills Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced (or) WIFE of Wesley Hubbs

6 DATE OF BIRTH (month, day, and year) Dec 20 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adalena Sheets

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Lana Lukenbaugh (Address) Owings Mills Md

15 MAY 9 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/ 1922

17 I HEREBY CERTIFY, That I attended deceased from May - 7, 1922, to May - 7, 1922, that I last saw her alive on May - 7, 1922, and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Strangulated umbilical Hernia.

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Intestinal Cancer

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of May 4/22

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Morton L Carr, M. D.

5/12, 1922 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Thomas Cemetery

DATE OF BURIAL May 8 1922

20 UNDERTAKER J. F. Elsie

ADDRESS Reisterstown

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64135

CERTIFICATE OF DEATH.

179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 10 Broadway ST., 27 WARD)

2-FULL NAME Mrs. Emma L. Kohlhepp

(a) RESIDENCE NO. 1100 Arlington Ave ST., Towars WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Kohlhepp

6 DATE OF BIRTH (month, day, and year) Dec 13 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) D37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Brotherton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Jos. Kohlhepp 1100 Arlington Ave Towars

MAY 9 - 1922 Filed J. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3 1922 to May 6 1922

that I last saw h[illegible] alive on May 6 1922

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic interstitial Nephritis.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard J. Coblentz, M. D.

19 (Address) Church Home and Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 19

UNDERTAKER Wm. J. Tickner & Son

ADDRESS N. Y. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 64136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1885 D 64136

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital ST. WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Spellman

(Residence in Baltimore: No. 718 N Lakewood ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 10th, 1873
(Month) (Day) (Year)

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Packer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Skillman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura L. Skillman

(Address) 718 N Lakewood ave

15- Filed MAY 9 1922, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Head

Duration Hours

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, May 10th, 1922

20-UNDERTAKER Robt F Turner Inc

ADDRESS 1442 N Broadway.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64137

CERTIFICATE OF DEATH.

11-081 B 64137

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3621 Falls Road ST.; 13 WARD)

2-FULL NAME William Franklin Ryan

(a) RESIDENCE. NO. 3621 Falls Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Isabella Foxin Ryan

6 DATE OF BIRTH (month, day, and year) Sept 8 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer His own

9 BIRTHPLACE (city or town) (State or country) Magnolia Maryland

PARENTS

10 NAME OF FATHER Thomas Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabella Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chester Co Pa

14 Informant (Address) Mrs Isabella Foxin Ryan 3621 Falls Road

15 Filed MAY 8 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 30 1922 to May 7th 1922, that I last saw h alive on May 6th 1922, and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. 8 ds.

CONTRIBUTORY. (Secondary) Bronchial Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) R B Norment M. D.

May 8 1922 Address) 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Govans M E Mays C. DATE OF BURIAL May 10 1922

20 UNDERTAKER A S Marshall ADDRESS 3539 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M.& T.—2000 Bks.

D 64138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 14 WARD) 101-001

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Deborah R. Bond

(Residence in Baltimore: No. 1520 David Hill Av St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 19, 1866
(Month) (Day) (Year)

7-AGE, 55 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Samuel Johnson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER — Giles

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. Bond

(Address) 1520 David Hill Av

15-MAY 9 - 1922 ROBERT R. KRAUTER,
Filed....., 191... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922, to May 8 1922, that I saw her alive on May 7 1922, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

..... (Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Dr Stemmer

..... (Duration) ....yrs. ....mos. 8 ds.

(Signed) R. R. Florden M. D.

May 8, 1922 (Address) 712 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, May 10, 1922

20-UNDERTAKER John A. Bishop & Son

ADDRESS 1017 Druid Hill Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64139

CERTIFICATE OF DEATH.

37 D 64139

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., 1 WARD)

2-FULL NAME Benjamin Worsham

(a) RESIDENCE NO. 217 E. East St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: — —

6 DATE OF BIRTH (month, day, and year): Nov 2, 1921

7 AGE: Years — Months 6 Days — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Worsham

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lupan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed MAY 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 8, 1922, that I last saw him alive on May 8, 1922, and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) 0 yrs. 0 mos 21 ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal fluid findings

(Signed) H. H. Wyeth, M. D.

May 9, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: May 10 1922

20 UNDERTAKER: Frankenthaler & Finkelstein — ADDRESS 1734 Eager

mation should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 64140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64140

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1924 n Dallas ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Henry White

(Residence in Baltimore: No. 1718 E. Madison St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Married

6-DATE OF BIRTH, July (Month) 4 (Day), 1850 (Year)

7-AGE, 71 yrs. 10 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer Prob Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) City Hall

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry White

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Clara Blackstone

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah L. White

(Address) 1718 E. Madison

15- Filed MAY 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Katz Stuller M. D. (Coroner.)

5-8, 1922 (Address) 4 E. Oliver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, May 10, 1922

20-UNDERTAKER Pinkler & Pinkler

ADDRESS 1739 Eager St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 64142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 64142

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 So Howard ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Flynn

(Residence in Baltimore: No. 730 N. Gay St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, May 30, 1884
(Month) (Day) (Year)

7-AGE, 37 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman Sewing machines
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, John J. Flynn

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Elizabeth Nazrenaus

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude F. Flynn

(Address) 730 N. Gay st

15- MAY 9 - 1922 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition fed through tube

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Ruley M. D.
(Coroner)

5-8, 22 (Address) 4 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Western — DATE OF BURIAL, May 11, 1922

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager st

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64142

D 64142

CERTIFICATE OF DEATH.

REGISTERED NO. C 112

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2110 Mc Culloh ST. 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert L. Austin

(Residence in Baltimore: No. 2110 Mc Culloh St.: 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) ..... (Day) 1865 (Year)

7-AGE, 57 yrs. 1 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Robert L Austin Sr

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lucinda Smith

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elizabeth Austin

(Address) 2110 Mc Culloh St.

15- FILED MAY 9 - 1922 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 9 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May - 8 - 1922, to May 9 - 1922, that I saw him alive on May 8 - 1922, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows: (Corr.)

Acute Indigestion

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Gastritis

(Duration) ..... yrs. 7 mos. 1 ds.

(Signed) W. J. Williams M. D.

May 9, 1922 (Address) 2035 E Mc Culloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dr Kaufman — DATE OF BURIAL, May 11, 1922

20-UNDERTAKER Lawrence E Wright — ADDRESS 1364 W Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64143

CERTIFICATE OF DEATH.

1/D 64143

001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 E Preston ST., 9 WARD)

2-FULL NAME Charlie Rollings Foxgelein

(a) RESIDENCE NO. 836 E. Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	19	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baum & Howard

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Bernard Foxgelein

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Lewis

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Bernard Foxgelein
(Address) 836 E. Baum St

15 Filed MAY 9 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to May 7, 1922,

that I last saw h in alive on May 6, 19...

and that death occurred, on the date stated above, at 4-30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Pearce, M. D.

May 8 19 24 (Address) 5 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 10 1922

20 UNDERTAKER Wm Cook — ADDRESS ... E. ... St.

Spec.—1-10-21—M&T—1500 Bks.

D 64144 HEALTH DEPARTMENT—CITY OF BALTIMORE, MD D 64144

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO.) Christs Institution Hospital 704 Ensor ST., 9 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agustina Watkins

(a) RESIDENCE NO. 202 Hillen Road ST., WARD Halifax Co. N. Co.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Brown Watkins

6 DATE OF BIRTH (month, day, and year): May 8th 1866

7 AGE: Years 56; Months —; Days —; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9 BIRTHPLACE (city or town) Halifax Co. (State or country) North Carolina

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Elijah Sledge (Address) 22 Hillen Road Govan

15 Filed 9-1922 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 - 1922

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1922, to May 8 - 1922 that I last saw her alive on May 8 - 1922 and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:
apoplexy
asthma Dropsy + Bright Disease (duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary) asthma Dropsy + Bright Disease (duration) yrs. 6 mos. 10 ds.

18 Where was disease contracted if not at place of death? N.C

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. G. W. Kennard, M. D.
5-8, 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — DATE OF BURIAL: May 11 1922

20 UNDERTAKER: Fredk Lassahn & Sons — ADDRESS: Fullerton Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64145

CERTIFICATE OF DEATH.

10

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD 8)

2-FULL NAME George Mitchell.

(a) RESIDENCE. No. 1233 W. Washington St WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Myrtle Lowery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Hosp. Records

15 Filed Robert P. Harrison, Registrar

May 9-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922, to May 9, 1922, that I last saw him alive on May 8, 1922, and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Laryngeal diphtheria

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? culture pos.

(Signed) B. MacLennan, M. D.

5/9/22 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews Cemetery	May 9 1922

20 UNDERTAKER E. J. Fanning & Son-1938 E. Lafayette ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64146

CERTIFICATE OF DEATH.

139 D 64146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Stirling ST., 10 WARD)

2-FULL NAME Mary Bush

(a) RESIDENCE NO. 707 Stirling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Feb 3 1864

7 AGE: Years 58 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Richard Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co.

12 MAIDEN NAME OF MOTHER: Lydia Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tapp Co.

14 Informant: Mrs. C. Bush (Address) 1307 Orleans St.

15 5-9-1922, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-7-19 22

17 I HEREBY CERTIFY, That I attended deceased from 5-6-, 19 22, to 5-7-, 19 22, that I last saw her alive on 5-7-, 19 22, and that death occurred, on the date stated above, at 7,30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Uterine Fibroid (duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gargitt, M. D.

5-8-19 22 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen Cem. DATE OF BURIAL: May 11 1922

20 UNDERTAKER: Thos. J. Locke ADDRESS: 1302 Jeffrey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64147

CERTIFICATE OF DEATH.

REGISTERED NO. 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 Madison Ave ST. 13 WARD)

2-FULL NAME Fleece Kropman

(a) RESIDENCE NO. 2424 Madison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 29-1920

7 AGE — Years: 2 Months: 1 Days: 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Nathan Kropman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Anna Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant: Nathan Kropman (Address): 2424 Madison Ave.

15 Filed 1922 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/9/1922

17 I HEREBY CERTIFY, That I attended deceased from 4/30/22, 19 .. to 5/9/22, 19 22, that I last saw h alive on 5/9, 19 22, and that death occurred, on the date stated above, at 12 15 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

ORW

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Heart failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Goldberg M.D.

5/9, 19 22 (Address) 1220 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodeph Sholom DATE OF BURIAL: 5-9, 1922

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Measles developed after pneumonia.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64148

CERTIFICATE OF DEATH.

D 64148

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 300 Carlton ST. 18 WARD)

2-FULL NAME Ella Heard

(a) RESIDENCE. No. 300 Carlton Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	Col	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Heard

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Gunther Gale

(Address) 1008 Penna ave

15 May 19 1922 Registrar

[Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1922, to May 8th, 1922, that I last saw her alive on May 30th, 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Garnett Mark M. D.

5/9, 1922 (Address) 901 Smyth ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. L. Auburn Co. DATE OF BURIAL May 10 1922

20 UNDERTAKER Daniel Easton ADDRESS 916 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occu-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64149

CERTIFICATE OF DEATH.

D 64149

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1306 (Division ST.) 14 (WARD)

2-FULL NAME Georgianna Taylor —

(a) RESIDENCE. No. 1306 Division ST., 17 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George R. Taylor

6 DATE OF BIRTH (month, day, and year) 3-3-1862

7 AGE			
60 Years	2 Months	5 Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Mills

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Bozzman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Sarah Adley (Address) 706 Fisher st.

15 Filed MAY 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-6-1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1922, to May 6, 1922 that I last saw her alive on May 6 - 1922 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 6 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Ex Tonsilitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G B Hughes M. D.

5-8-1922 (Address) 1413 D. Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	5-11-1922
20 UNDERTAKER John Toadvine	ADDRESS 142 W Hill St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64150

CERTIFICATE OF DEATH.

723 D 64150

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD) 14

2-FULL NAME Anna Warren.

(a) RESIDENCE. NO. 1908 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of James Warren

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Princeton
(State or country) Illinois

PARENTS

10 NAME OF FATHER Charles Peterson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sweeden.

12 MAIDEN NAME OF MOTHER Anna Josephson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Sweeden.

14 Informant Mrs. Stearns
(Address) 1908 Linden ave

15 Filed MAY 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 9, 1922, that I last saw h[illegible] alive on May 9, 1922, and that death occurred, on the date stated above, at 2.15 p m.

The CAUSE OF DEATH* was as follows:

Ulcer of Duodenum with Pyloric Obstruction
Pericholecystitis. Cholelithiasis
(duration) yrs. 6 mos. ds.

CONTRIBUTORY Acidosis. Cardiac
(Secondary) Fracture (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1908 Linden Ave

Did an operation precede death? Yes Date of May 5, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) John W Whitehead, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 1922
20 UNDERTAKER	ADDRESS
Henry Lutz	1203 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

May 5, 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64154

161-00

D 64154

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2-FULL NAME Baby #1 of Bertha Abernathy

(a) RESIDENCE NO. 317 E 23rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or 16 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Abernathy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bertha Malon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL Records.

15 Filed MAY 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 4, 1922, that I last saw her alive on May 4, 1922, and that death occurred, on the date stated above, at 9.56 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL MAY 9 1922

20 UNDERTAKER

ADDRESS

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64152

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-09 D 64152

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Baby #2 of Bertha Abernathy

(a) RESIDENCE NO. 317 E. 23rd ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) May 4 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 18 min.
0	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Abernathy

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Mason

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Records.

15 MAY 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 4, 1922, that I last saw him alive on May 4, 1922, and that death occurred, on the date stated above, at 10-05 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) H. Cathrall M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

HOPKINS HOSPITAL
Commissioner Health.
MAY 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64153

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. Durham ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grover C. Statham

(a) RESIDENCE NO. 223 N. Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced (HUSBAND) of (or) (WIFE) of Emma Statham

6 DATE OF BIRTH (month, day, and year) Oct 24-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prospect Va

PARENTS

10 NAME OF FATHER Crawford Statham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Woodson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edith Johnson

(Address) 732 Eye & Saratoga Sts

15 MAY 1-0 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9-1922

17

I HEREBY CERTIFY, That I attended deceased from 5-2-, 19 22, to 5-9-, 19 22,

that I last saw him alive on 5-8-, 19 22,

and that death occurred, on the date stated above, at 3,45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Gorgill, M. D.

5-9-1922 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Va

DATE OF BURIAL May 10 1922

20 UNDERTAKER Sam'l H. Chase & Son

ADDRESS 1500 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64154

CERTIFICATE OF DEATH.

100-001

D 64154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 E Monument ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence May Estella Jones

(a) RESIDENCE No. 1609 E Monument St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) April 27. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
15 days				

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work ..... ditto

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimo. Co

12 MAIDEN NAME OF MOTHER Florence Hiland

13 BIRTHPLACE OF MOTHER (city or town) born in Baltimore (State or country)

14 Informant Mother Florence Jones

(Address) 1609 E Monument St

15 MAY 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8- 1922

17

I HEREBY CERTIFY, That I attended deceased from May 5- 1922, to May 8- 1922,

that I last saw her alive on May 8- 1922,

and that death occurred, on the date stated above, at 10.35 P. m.

The CAUSE OF DEATH* was as follows:

Convilsions & Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

5-9, 1922 (Address) 708 Edson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	May 10 1922
20 UNDERTAKER Mrs Robert A. Elliott	ADDRESS 1725 Ashland Av

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—1-10-21—M&T—1500 Bks.

D 64155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64155

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Mosher ST., 16 WARD)

2-FULL NAME Infant Payne.

(a) RESIDENCE NO. 1218 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days | If LESS than 1 day, hrs. or 8 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Alex. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales, Md

12 MAIDEN NAME OF MOTHER Bertha Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant (Address) Bertha Payne

15 Filed MAY 10 1922 J. H. Wilkinson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 8, 1922, that I last saw h alive on May 8, 1922, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prenatal Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Knapp, M. D.

5/9 1922 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: May 10 1922

20 UNDERTAKER: James H. Dennis

ADDRESS 1203 Greenmount

INFORM should be given by Informant. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1557 D 64156 — D 64156

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. .....) ST., 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Samuels

(a) RESIDENCE NO. 2229 Division St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 20-1921

7 AGE — Years: 0 — Months: — Days: 21 — If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): — 000

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: James Samuels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Alice Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL Hospital

15 Filed MAY 10 1922 F. E. Wilm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 - 1922, to May 9 - 1922

that I last saw him alive on May 9 - 1922,

and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, miliary

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Tbcle and Xray -

(Signed) T B Gay, M. D.

, 19 (Address) Johns Hopkins Hosp-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: May 11 1922

20 UNDERTAKER: Jacques & Demuth — ADDRESS 1213 Frederick

mation should be carefully supplied. AGE should be stated in the Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *septicemia, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lungs & brain involved.

Spec.—1-10-21—M&T—1500 Bks.

D 64157 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 64157

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Cherry St., Curtis Bay ST., 25 WARD)

2-FULL NAME Kazemer Griber

(a) RESIDENCE NO. 1 Cherry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) Nov. 1st 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ×

(b) General nature of industry, business, or establishment in which employed (or employer) ×

(c) Name of employer ×

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Md.

PARENTS

10 NAME OF FATHER Mateusz Griber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Eva Polcianski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mateusz Griber

(Address) 1 Cherry St.

15 Filed MAY 10 1922 F. E. Wehr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to May 10, 1922, that I last saw him alive on May 9, 1922, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Geo. B. Davis, M. D.

5/10, 1922 (Address) 211 Church St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R.C. Cem.	May 11 1922
20 UNDERTAKER	ADDRESS
John Grebliunas	425 S. Pera

mation should be carefully supplied. AGE should be given in years. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64158

D 64158

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2911 Spring Hill av ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Jennie~~ Jennie S Kear

(a) RESIDENCE. NO. 2911 Spring Hill av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. ~~none~~

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Isaac Gerber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Hanna Snyder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Louis Goldsmith (Address) 1702 Linden ave

15 Filed MAY 10 1922, 19 J. E. Weber Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to May 9, 1922, that I last saw h~~er~~ alive on May 9, 1922, and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Aortic regurgitation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? none.

(Signed) Chas H Eastold. M. D.

, 19 (Address) 221 S. B'way.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cemetery

DATE OF BURIAL May 10 1922

20 UNDERTAKER Max Levinson

ADDRESS 127 E Baltic St.

mation should be carefully supplied. Also know CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64159 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64159

CERTIFICATE OF DEATH.

REGISTERED No. C 17

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 424 N. Fremont St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph M. Johnson

(Residence in Baltimore: No. 424 N Fremont St St. Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1874
(Month) (Day) (Year)

7-AGE, 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman 073
(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

9-BIRTHPLACE, (State or Country), Md. U.S.

PARENTS.

10-NAME OF FATHER, Richard Johnson

11-BIRTHPLACE OF FATHER (State or Country), Penn. U.S.A.

12-MAIDEN NAME OF MOTHER Esther Mercer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Homer Johnson

(Address) 727 Vincent Ave

15- MAY 10 1922

Filed ....., 191. J. H. Helm Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 5 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Bled to death from severed ulnar artery in R. Arm. Also illuminating gas ..... (Duration) ½ yrs. a few mins. mos. ds.

CONTRIBUTORY (Secondary) Suicide ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D.
(Coroner.)

5-9, 1922 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Fort Mich	....., 19....
20-UNDERTAKER	ADDRESS
Chas J. Fehrenbacher	35 Eutaw

Information should be carefully supplied. AGE and OCCUPATION must be filled EXACTLY. HUSBAND and WIFE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64160

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 911 Hillen ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Perry

(a) RESIDENCE NO. 911 Hillen ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Perry

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 33 — Months: — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jeremiah Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): James Wallace 901 Hillen St.

15 Filed MAY 1 01922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922, to May 8 - 1922, that I last saw her alive on May 8 - 1922, and that death occurred, on the date stated above, at 8, P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 28 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D Gilchrist, M. D.

5-9, 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: May 11 1922

20 UNDERTAKER: Clement Hall — ADDRESS: 909 Hillen St

mation should be carefully supplied. And it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 64161

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Calvin Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Lucille Brillhart

(Residence in Baltimore: No. 403 Calvin Ave St.; 38 yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, October 9, 1883
(Month) (Day) (Year)

7-AGE, 38 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Harry N Hopkins

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Thomas Brillhart

(Address) 403 Calvin Ave

15 MAY 1 01922 ROBERT R. KRAUTER, Registrar.

Filed....., 191..... Burial Permit Issued.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15 1919, to May 8 1922, that I saw h er alive on May 8 1922, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

1. Arteriosclerosis
2. Myocarditis
3.
4.

(Duration) 2 yrs. 4 mos. 13 ds.

CONTRIBUTORY (Secondary) .....

(Duration)..... yrs..... mos..... ds.

(Signed) [illegible] M. D.

May 9, 1922 (Address) 1413 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
First German Reformed Evangelical Congregational Cem	May 11, 1922
20-UNDERTAKER	**ADDRESS**
Harry A Annacost	4204 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 64162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Eastern ave & 26th St.: 26 WARD)

2-FULL NAME Thomas E. Clark

(a) RESIDENCE. No. Eastern ave & 26th St., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Clark

6 DATE OF BIRTH (month, day, and year) Sept 2nd 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer Baltimore Oil Engine Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Grace Ann Downfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Clark

(Address) Belair Maryland

15 Filed MAY 10 1922 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28 1922 to May 10 1922

that I last saw him alive on May 9 1922

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Nephritis acute

OVR

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A B Titlow M. D

5/10. 1922 (Address) 315 S. Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Francis Cemetery Abingdon

DATE OF BURIAL May 12 1922

20 UNDERTAKER Howard K McCann

ADDRESS Abingdon

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition than hard labor.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64163 — 74 — 81 — D 64163

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1309 Harlem Ave. St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna B. Roschen

(Residence in Baltimore: No. 1309 Harlem Ave. St. yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. January (Month) 13th (Day) 1860 (Year)

7-AGE. 62 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER. Herman D. Roschen

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER. Adelheid Brockwehl

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lisette A. Rosch[illegible]

(Address) 214 N. Fulton Ave[illegible]

15- FILED MAY 10 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 8th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Cor. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) more back.

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

May 8" 1922. (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	May 10, 1922
20-UNDERTAKER. Joseph B Cook	ADDRESS 1631 N. Balto St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dorothy E. Wagner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64164

CERTIFICATE OF DEATH.

161-001

D 64164

REGISTERED NO.....

1-PLACE OF DEATH 1716 N. Rutland Ave

CITY OF BALTIMORE: (No. 1716 ST.: Rutland WARD 8)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Elaine Baby of Wagner.

(a) RESIDENCE. NO. 1716 N. Rutland Ave ST.: ..... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 9 1922

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or ... min.
	—	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER Elmer E. Wagner

11 BIRTHPLACE OF FATHER (city or town) Balto - (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Harpel

13 BIRTHPLACE OF MOTHER (city or town) Balto - (State or country) Md.

14 Informant (Address) H Hospital Records.

15 Filed MAY 1 01922 19 ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to May 9 1922, that I last saw her alive on May 9, 1922, and that death occurred, on the date stated above, at 6.05 P.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) H H Cathcart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 10 1922
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64165

CERTIFICATE OF DEATH.

179 D 64165

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Dr. Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fountain

(a) RESIDENCE NO. 870 Vine St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible] 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city

PARENTS

10 NAME OF FATHER: John Fountain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jonza Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma Frost (Address) 870 Vine St

15 MAY 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 9, 1922, that I last saw him alive on May 9, 1922 and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Newton J Pare, M. D.

, 19 (Address) Franklin Dr. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn

DATE OF BURIAL: May 11 19 22

20 UNDERTAKER: A & Gross

ADDRESS: 1405 McCulloh

mation should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1) 64166

CERTIFICATE OF DEATH.

10 D 64166

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 764 Dolphin St. (Ward) 17

2-FULL NAME Charles Smith

(a) RESIDENCE NO. 764 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 6, 1918

7 AGE — Years: 4 — Months: 1 — Days: 3 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ~ 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Elberton Georgia

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER Jennie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Elberton Ga

14 Informant: Jennie Smith

(Address): 764 Dolphin St.

15 Filed MAY 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922, to May 9, 1922

that I last saw him alive on May 9, 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

Intubation

(duration) Intubation yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Schmidt M. D.

May 9 1922 (Address) 1534 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: May 10 22

20 UNDERTAKER: R. E. Ball

ADDRESS: 1405 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

FOR MEMORANDUM ONLY

139 D 64167

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 N. Caroline ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johannah Horrigan

(a) RESIDENCE. NO. 1205 N. Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Cornelius Horrigan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dunworth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Mary A. Horrigan
(Address) 1205 N. Caroline St.

15 MAY 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to May 8, 1922,
that I last saw h.. alive on May 8, 1922,
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial
Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute congestion of
Lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Renton, M. D.

5/10, 1922 (Address) 1006 Chanell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/11, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF SPECIFIC TION is very important. See instructions on back of certificates.

D 64168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1207 St. Paul St. WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold Rome

(Residence in Baltimore: No. 1207 St. Paul St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6-DATE OF BIRTH, ..., 1871
(Month) (Day) (Year)

7-AGE: 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Lab

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: James Taylor

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Hannah Davis

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Taylor

(Address) 120 E. St. James St.

15- Robert P. Harrison,

Filed ....., 191.....

10 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyst of Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

5-8-22, 192 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt. Zion Cem. | DATE OF BURIAL: May 11, 1922

20-UNDERTAKER: Brown & Holland | ADDRESS: 614 N. Schroeder St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64169

CERTIFICATE OF DEATH.

D 64169
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 117 S. Bond ST.; (3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Kramer

(a) RESIDENCE. No. 117 S. Bond ST., 3rd WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Germany

7 AGE: Years 60 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None 400
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS
10 NAME OF FATHER: Phillip Caplan
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER: Mollie Caplan
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Isidore L. Kramer
(Address) 117 S. Bond St

15 Filed MAY 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to May 10, 1922,
that I last saw her alive on May 6, 1922,
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
arteriosclerosis

2
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cholelithiasis
Sudden (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank R. Smith, M. D.
5/10, 1922 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — DATE OF BURIAL: May 11 1922

20 UNDERTAKER: Max Forman — ADDRESS 1127 E. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64170

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 64170

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1518 E Clement St. 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria Morris

(Residence in Baltimore: No. 1518 E. Clement St St.; 2 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-~~SEX~~ Female

4-COLOR OR RACE White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH July (Month) 9th (Day) 1919 (Year)

7-AGE 2 yrs. 10 mos. 0 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10-NAME OF FATHER Andrew Morris

11-BIRTHPLACE OF FATHER (State or country) Austria

12-MAIDEN NAME OF MOTHER Katie Sliva

13-BIRTHPLACE OF MOTHER (State or country) Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Morris

(Address) 1518 E Clement St

15- Filed MAY 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May (Month) 9th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 8th, 1922, to, May 9th 1922 that I saw h alive on May 9th 1922 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY) measles

(Duration) ..... yrs ..... mos. 6 days ds.

(Signed), T. J. Tanker M. D.

May 11, 1922 [Address] 119 N Milton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Cross Cem DATE OF BURIAL 5-11, 1922

20-UNDERTAKER E & B Harle ADDRESS 115 E West St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64172 — 161-08 — D 64172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2406 Wilkens Ave ST. 20 WARD)

2-FULL NAME Baby Sibley (no name)

(a) RESIDENCE. No. 2406 Wilkens Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 20 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Eldridge Sibley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ethel Adelaide Turner.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs Edna Sibley.
(Address) 2406 Wilkens ave.

15 Filed MAY 11 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 10, 1922, that I last saw him alive on May 10, 1922, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Ruland, M. D.

5-10, 1922 (Address) 2532 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 11 1922
20 UNDERTAKER	ADDRESS
Geo. L. Schwab &	210 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64172

CERTIFICATE OF DEATH.

D 64172

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... St. 13 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo M. Carback.

(a) RESIDENCE. No. 822 Wellington St., ... Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Mrs Clara Carback

6 DATE OF BIRTH (month, day, and year) Aug 4 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Textile Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 046

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Carback

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant (Address) Hosp Records.

15 Filed MAY 11 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1922, to 5/10, 1922, that I last saw him alive on 5/10/, 1922 and that death occurred, on the date stated above, at 3:10 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver.

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings

(Signed) Thos Riordan, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 13 22
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut Ave

MAKE STRONG CARBON SUPPLIED. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64173

D 64173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3127 Cedar Ave St., 13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A Spence

(a) RESIDENCE NO. 3127 Cedar Ave St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Spence

6 DATE OF BIRTH (month, day, and year): Jun 31 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler Tester

(b) General nature of industry, business, or establishment in which employed (or employer): for Pa. R.R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Florence Spence
(Address): 3127 Cedar Ave

15 MAY 11 1922

ROBERT R. KRAMER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-5, 1922, to 5-9, 1922

that I last saw h alive on 5-9, 1922

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms

(Signed) C Houghton, M. D.

5-10 1922 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int Olivet Cem — DATE OF BURIAL: May 13 1922

20 UNDERTAKER: Ehrenworth & Son — ADDRESS: Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64174

CERTIFICATE OF DEATH.

D 64174

REGISTERED NO. 33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospl. St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Parker

(a) RESIDENCE. No. 2844 N Calvert St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Wife

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany 29 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Roland Park Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Jno Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Cutis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Catharine C. Parker
(Address) 2844 N. Calvert St

15 Filed ..., 19 ... Registrar

MAY 11 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/20/22, 19..., to May 11/22, 19...,
that I last saw her alive on May 8/22, 19...,
and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. about 3 weeks mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dil.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Pancoast, M. D.

, 19 (Address) Md Gen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 13. 1922

20 UNDERTAKER	ADDRESS
John Crutchett	1201 N. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64175

CERTIFICATE OF DEATH.

179 D 64175

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3017 Winfield Ave (WARD) 15

2-FULL NAME George H Berry

(a) RESIDENCE: No. 3017 Winfield Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Widower Mary S Berry

6 DATE OF BIRTH (month, day, and year): Nov 2 1848

7 AGE: Years 73 Months 6 Days ..... If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Richard De Bates

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co.

12 MAIDEN NAME OF MOTHER: Mary E Singer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Louis H Gorsuch

(Address) 3017 Winfield Ave

15 MAY 11 1922 ROBERT R. KRAUTER, Registrar

Fatherland Homestead

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1921, to May 9, 1922

that I last saw h.. alive on May 9, 1922

and that death occurred, on the date stated above, at 6 45 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 3 yrs. mos ds

CONTRIBUTORY (Secondary) Chronic Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis H Gorsuch, M. D.

, 19 (Address) 2724 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: May 9 1922

20 UNDERTAKER: William Baker & Son

ADDRESS: Cir

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64176

D 64176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. Monford ave. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Celesta Wisniewski

(a) RESIDENCE NO. 121 N. Monford ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodlawn Heights Md Co Md

PARENTS

10 NAME OF FATHER Stephen Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Helen Swanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Stephen Wisniewski
(Address) 121 N Montford ave

15 Filed MAY 11 1922 Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17th 1922 to May 10th 1922

that I last saw her alive on May 10th 1922

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Measles.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical Symptoms

(Signed) Amelia E Link, M. D.

5/10 1922 (Address) 1717 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL May 12 1922

20 UNDERTAKER William Cook ADDRESS 50 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64177.

CERTIFICATE OF DEATH.

113 D 64177.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Bruce St. St. 21 WARD)

2-FULL NAME James William Cook

(a) RESIDENCE. No. 1113 Bruce St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col.	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [redacted]

6 DATE OF BIRTH (month, day, and year) Apr. 1st 22

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	One	Nine	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Edmonia Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edmonia Cook
(Address) 1113 Bruce St

15 MAY 11 1922 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1922, to May 9th, 1922, that I last saw h[illegible] alive on May 9th, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Intestinal Intoxication

(duration) yrs. mos. 1? ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Carroll, M. D.

6/1.1922 (Address) 1400 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 5/11/22 19

20 UNDERTAKER Sam'l W. Chase-son — ADDRESS 1400 Riskin at

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 D 64178

REGISTERED No. C

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

D 64178

CITY OF BALTIMORE (No. 711 Appleton St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Quill

(Residence in Baltimore: No. 711 Appleton St.: 45 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: ..... (Month) ..... (Day) 1844 (Year)

7 AGE: 78 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9 BIRTHPLACE (State or country): Scotland

PARENTS

10 NAME OF FATHER: Alexander McMurdy

11 BIRTHPLACE OF FATHER (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Mary Watt

13 BIRTHPLACE OF MOTHER (State or country): Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Keeler

(Address) 711 N Appleton

15. MAY 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 9th (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 1st, 1922 to May 9th 1922 that I saw her alive on May 9, 1922 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. — mos. — ds

Contributory (SECONDARY) Uremia

(Duration) 1 yrs. 1 mos. 3 ds.

(Signed) Thomas L. Talbott M. D.

May 11, 1922 (Address) Marlborough Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral

DATE OF BURIAL: May 12, 1922

20 UNDERTAKER: Martin Luther Wilson

ADDRESS: 1821 N North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64179

D 64179

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Cypress St., Curtis Bay ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME baby Miller

(a) RESIDENCE NO. 2 Cypress St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10 - 22

7 AGE Years Months Days If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Curtis Bay, Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Martin Luther Miller

11 BIRTHPLACE OF FATHER (city or town) Frdk. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle H. Bromley

13 BIRTHPLACE OF MOTHER (city or town) Camden (State or country) N.J.

14 Informant Myrtle H. Miller

(Address) 2 Cypress St. Curtis Bay

15 Robert F. Harrison, Registrar

MAY 11 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 10, 1922, that I last saw him alive on May 10, 1922, and that death occurred, on the date stated above, at 9:10 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(at about 5 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. B. Davis, M. D.

5/11/, 1922 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

MAY 11 1922

Please write plainly. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64180

CERTIFICATE OF DEATH.

74-00

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Edmondson Avenue ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah G. Carey

(a) RESIDENCE. NO. 1029 Edmondson Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? 52 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Carey

6 DATE OF BIRTH (month, day, and year): May 31, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edward Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Harry J. Daly
(Address): 1029 Edmondson Avenue

15 Filed ....., 19 .....
Registrar

11 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to May 9, 1922, that I last saw her alive on May 9, 1922, and that death occurred, on the date stated above, at 11-50 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) ✓ yrs. ✓ mos. 19 ds.

CONTRIBUTORY (Secondary): Paralysis Agitans & Chronic Nephritis

(duration) over 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Henry J. Daly M. D.

May 10-1922 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/12, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day or a year, state in HOURS or MINUTES. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64181

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Harlem Avenue ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ambrose Seim

(a) RESIDENCE. NO. 1027 Harlem Avenue ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie E. Wright

6 DATE OF BIRTH (month, day, and year): Dec. 7, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Seim

11 BIRTHPLACE OF FATHER (city or town): Germany
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Jane Smith

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Maryland

14 Informant: Mrs. Annie E. Seim
(Address): 1027 Harlem Avenue

15 Filed ..... 19 ..... Registrar: Robert P. Harrison

MAY 11 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9" 1922

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to May 9", 1922, that I last saw h/m alive on May 9", 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Disease of Heart
Incipient
(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm. B. Rider, M. D.

(Address) 867 Harlem Ave

May 11 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 5/12, 1922

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64182

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 E. North Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Dean

(a) RESIDENCE. No. 423 E. North Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael J. Dean

6 DATE OF BIRTH (month, day, and year) July 15-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House 037

(b) General nature of industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Wm B. Tolyn

(Address) 423 E. North Ave

15 MAY 11 1922 19 Robert P. Harrison, Registrar

...Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 , 1922 , to May 9 , 1922 ,

that I last saw her alive on May 8 , 1922 ,

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Myo+endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton , M. D.

5/10 1922 (Address) 707 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 12 1922

20 UNDERTAKER J. C. Windsfeld ADDRESS 9 Dumont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64183

CERTIFICATE OF DEATH.

D 64183

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 Presstman ST.; 14 WARD)

2-FULL NAME James A. Bruce

(a) RESIDENCE. No. 547 Presstman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Sam'l A. Bruce

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Clementine Hinson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Roscoe Bruce
(Address) 547 Presstman

15 Filed MAY 11 1922, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1922

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1922, to May 9, 1922, that I last saw him alive on May 9, 1922, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio-vascular Disease
(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

5/10, 1922 (Address) 2000 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	5-12 192
20 UNDERTAKER George H. Holland	ADDRESS 1631 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 11 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64134

CERTIFICATE OF DEATH.

D 64134

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. 287

CITY OF BALTIMORE: (No. 7 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hyde

(a) RESIDENCE. No. Fredrickstown Pa ST., WARD. Fredericktown Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Don't know

(b) General nature of industry, business, or establishment in which employed (or employer) 187

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna Don't know

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Hebrew Hospital (Address)

15 Filed MAY 11 1922 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-4, 1922, to 5-10, 1922, that I last saw him alive on 5-10, 1922, and that death occurred, on the date stated above, at 5-20 p m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pericardial Effusion

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 5-4-22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Zinberg M. D.

5/11, 19 22 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Laurel Pa

DATE OF BURIAL 5/11 1922

20 UNDERTAKER Chas. H. Grant & Son

ADDRESS 1118 N. Mt Royal

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64185 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64185

CERTIFICATE OF DEATH. 1884 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mack A. Jones

(Residence in Baltimore: No. Laurel, Md. St.; yrs. ..... mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

6-DATE OF BIRTH. April (Month) ..... (Day) 1867 (Year)

7-AGE. 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Agriculturist
(b) General nature of industry, business, or establishment in which employed (or employer). (cattle) dlr

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER. [illegible]

11-BIRTHPLACE OF FATHER, (State or Country). [illegible]

12-MAIDEN NAME OF MOTHER. [illegible]

13-BIRTHPLACE OF MOTHER, (State or Country). [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) Md. Gen. Hosp.

15- Robert P. Harrison,

Filed ..... 192 ..... Registrar.

MAY 11 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Knocked down in Bull Pen

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

May 11 1922 (Address) 2 E. Main St. Cumberland, Md.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Laurel, Md.

Former or usual residence Columbus, Ohio.

19- ~~DEATH OR BURIAL~~ OR REMOVAL, Laurel Md. DATE OF BURIAL, May 11 1922

20-UNDERTAKER, E. B. Harla ADDRESS 115 E. Main St.

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64186

CERTIFICATE OF DEATH.

101 D 64186

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 740 St Peter ST. (WARD) 21

2-FULL NAME David E Whistler

(a) RESIDENCE NO. 740 St Peter ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Widower of Mary E Whistler

6 DATE OF BIRTH (month, day, and year): Aug 1 1857

7 AGE: Years 62 Months 8 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Whistler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Margaret Irving

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Lodger 740 St Peter St

15 Filed May 11 1922, 19 ..... Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to May 10, 1922, that I last saw h— alive on May 9, 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? —

What test confirmed diagnosis? .....

(Signed) Harry Boyd, M. D.

5-10, 1922 (Address) 60 E Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: May 12 1922

20 UNDERTAKER: William Balsley — ADDRESS: Natha

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 11 1922

Spec. 1-10-21 M&T 1500 Bks.

Troup 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64187.

D 64187

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 403 W. 28 ST., 17 WARD)

2-FULL NAME Blanch Fremont Troup

(a) RESIDENCE NO. 403 W. 28 ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. Pub

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Marysville (State or country) Pa

PARENTS

10 NAME OF FATHER John Troup

11 BIRTHPLACE OF FATHER (city or town) Newport (State or country) Pa

12 MAIDEN NAME OF MOTHER Justina Stoon

13 BIRTHPLACE OF MOTHER (city or town) Marysville (State or country) Pa

14 Informant John Troup (Address) 40 W. 28

15 Robert F. Harrison, Burial Permit Clerk. 19 Registrar

MAY 11 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922 to May 10, 1922, that I last saw h alive on May 10, 1922 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma

(duration) 1 yrs. — mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 15, 22

Was there an autopsy? No

What test confirmed diagnosis? Stomach analysis

(Signed) J. Jen Magruder M. D.

5/11, 1922 (Address) 1900 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marysville Pa	May 13 1922
20 UNDERTAKER	ADDRESS
William Cook	503 E Monte

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64188

D 64188

CERTIFICATE OF DEATH.

123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. N. Broadway ST., 726 WARD)

2-FULL NAME Mrs. Elizabeth Trentler

(a) RESIDENCE NO. 3301 Colgate ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Trentler

6 DATE OF BIRTH (month, day, and year): Jan 3 1864

7 AGE — Years: 57 Months: 9 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: George Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Fogner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Geo. Trentler (Address): 3301 Colgate St.

15 Filed ....., 19 ..... Registrar

Robert P. Hardison, Burial Permit Clerk.

11 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1922.

17 I HEREBY CERTIFY, That I attended deceased from 4-26-22, 1922, to 5-9, 1922, that I last saw her alive on May 9, 1922, and that death occurred, on the date stated above, at 4.33 a.m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart,

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary) Cholettiasis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known,

Did an operation precede death? yes Date of 1-26-22,

Was there an autopsy? not.

What test confirmed diagnosis? Clinical Exam,

(Signed) Isaac Freed, M. D.

, 19 (Address) Alexandra apts B-1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 5-12th 1922

20 UNDERTAKER: J. A. Moran

ADDRESS 3 00 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64189 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3rd & Patterson Ave ST., 25 Belair WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora L. Miller

(a) RESIDENCE NO. 3rd & Patterson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: Bernard Miller

6 DATE OF BIRTH (month, day, and year): — 1852

7 AGE: Years 70 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sally Fiske

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma Steuer (Address) 3rd & Patterson Ave

15 MAY 11 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5 1922, to May 10, 1922, that I last saw h alive on May 10, 1922, and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo D Davis, M. D.

5/11, 1922 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: 5/13 1922

20 UNDERTAKER: Wm. F. Fahy & Co ADDRESS: 35 Light St

MAY 11 1922

Spec.—1-10-21—M&T—1500 Bks. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64190

CERTIFICATE OF DEATH.

D 64190

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Md Gen Hospl ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Spilman

(a) RESIDENCE. NO. 400 W 23rd St ST., WARD. Washington D C

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 20, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D C.

PARENTS

10 NAME OF FATHER Thomas Spilman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rachael Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt F Chenoweth
(Address) 400 Chestnut Ave

15 Filed MAY 11 1922 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26 1922, 19..., to July 11 1922, 19...,
that I last saw him alive on July 11 1922, 19...,
and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Chronic Nephritis

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cerebral Dis

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. A. Hopkins, M. D.

, 19 (Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D C	May 11 1922

20 UNDERTAKER Chenoweth Son Chestnut Ave

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64191

CERTIFICATE OF DEATH.

101,001 D 64191

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 3d Ave. Wagners Ct. ST., 25 WARD)

2-FULL NAME Kazmierz Matuszak.

(a) RESIDENCE NO. 100 3d Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 4-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ddd

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Stanislaw Matuszak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Antonina Gozak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant St. Matuszak (Address) Wagners Ct

15 MAY 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922, to May 9, 1922, that I last saw h— alive on May 10, 1922, and that death occurred, on the date stated above, at 8:10 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Edema of the Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Bonn M. D.

5/11 1922 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: May 12, 22

UNDERTAKER: Wm. J. Lafferty

ADDRESS: 1618 Eastern

M.B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Clopton ✓ 2919 Huntingdon Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64192

64192

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 Hyman Ave ST., 17 WARD)

2-FULL NAME Anna Carnes

(a) RESIDENCE NO. 303 Hyman Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Carnes

6 DATE OF BIRTH (month, day, and year) April 9 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	56	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Behrens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorthy Bruman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Alvin Beebe

(Address) 303 Hyman Ave

15 MAY 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from February 21, 1922, to May 10th, 1922, that I last saw her alive on May 10th, 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Diabetes-Sclerosis

(duration) 1 yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) 2 yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? Yes Date of April 29, 1922

Was there an autopsy? No

What test confirmed diagnosis? 2

(Signed) William G. Clopton, M. D.

, 19 (Address) 2919 Huntingdon Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ward Lawn	May 13 1922
20 UNDERTAKER Geo Cook	ADDRESS Balto Md

N. B.—Answers to questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64193

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles B. Balser.

(Residence in Baltimore: No. Acaciaville, Digby Co. N. S. Canada. St., ~~yrs.~~ ~~mos.~~ 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. August 18th. 1903. (Month) (Day) (Year)

7-AGE. 18 yrs. 8 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Coal passer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... S/S Moldegard.

9-BIRTHPLACE, (State or Country). Nova Scotia, Canada.

PARENTS.

10-NAME OF FATHER, George Balser.

11-BIRTHPLACE OF FATHER, (State or Country). Canada.

12-MAIDEN NAME OF MOTHER, Kezian Cossett.

13-BIRTHPLACE OF MOTHER, (State or Country). Canada.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Balser, (brother)
Acaciaville, Digby Co.
(Address)...Nova Scotia, Canada.

15- Filed MAY 12 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Autopsy & (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sebticaemia, due to a bistol shot wound in the abdomen. Accidentally inflicted by his brother Frank Balser. (Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary) ..... (Duration)...yrs...mos...ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

May 11th 1922 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? S/S Moldegard, Curtis Bay. 5/6/22.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Digby Canada	May 12 1922
20-UNDERTAKER. John F. Denny	ADDRESS 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64194

CERTIFICATE OF DEATH.

46 D 64194

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2705 Keyworth Ave ST. 15 WARD)

2-FULL NAME Adelaide Latimer Blaney

(a) RESIDENCE NO. 2705 Keyworth Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, with ordinary pen and ink. Fill in all blanks with information. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Geo W. Blaney

6 DATE OF BIRTH (month, day, and year) May 15 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Portsmouth Va

PARENTS

10 NAME OF FATHER James L. Latimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Sarah Ann Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dr. Geo. W. Blaney

(Address) 2705 Keyworth Ave

15 Filed MAY 12 1922 J. E. Weber Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to May 10, 1922, that I last saw her alive on May 10, 1922, and that death occurred, on the date stated above, at 5-10 P m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Asthenia

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept. 1920

Was there an autopsy? No

What test confirmed diagnosis? Operative Exam.

(Signed) J. Wesley Cole M. D.

5/11, 1922 (Address) 2202 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 12, 1922
20 UNDERTAKER Wm J. Eckenrode	ADDRESS Norfolk Va

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64195

CERTIFICATE OF DEATH.

90 D 64195

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 W. Baltimore ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Dearing

(a) RESIDENCE. NO. 531 W. Baltimore ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec. 3rd 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Philip Dearing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Olich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lena Weyforth

(Address) 531 W. Baltimore St.

15 Filed MAY 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1922, to May 10, 1922, that I last saw h.r alive on May 9, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation -

Myocarditis -

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observations

(Signed) Harry S. McCarty, M. D.

5-10. 1922 (Address) 37 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 12th 1922

20 UNDERTAKER: Mr. & Mrs. John H. Teufel Son

ADDRESS: 801 W. Fayette St

INSTRUCTIONS: ...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(See Letter over) ✓

D 64196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Charles L. Smith (83) May 13 1922 REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 10 S. Arlington Ave.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Smith.

(Residence in Baltimore: No. 10 S. Arlington Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 1st (Day), 1873 (Year)

7-AGE, 48 yrs. 11 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Picture Frame Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Picture Frame Factory

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Ferdinand Smith.

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Smith

(Address) 10 S. Arlington Ave

15- Filed MAY 12 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1922, to May 10th 1922, that I saw him alive on May 10th 1922, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ... yrs. 12 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 10 yrs. ... mos. ... ds.

(Signed) Thomas [illegible] King M. D.

May 11 1922 (Address) 858 W. Lee [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? 114 Carlton St (S.)

Former or usual residence 10 S. Arlington Ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, May 13, 1922

20-UNDERTAKER John J. Fridez

ADDRESS 1200 W. Fayette

N. B.—Every item of information should be carefully supplied. Any error or omission may cause delay. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

DR. J. CHARLES NORTON
888 WEST LOMBARD ST.

TELEPHONE
GILMOR 89

OFFICE HOURS
9 TO 10 A. M.
2 TO 3 P. M.
7 TO 8 P. M.
SUNDAY BY APPOINTMENT

BALTIMORE, MD.

May, 13. 1921.

To whom it may Concern.

This is to certify that while making out the official "Death Certificate" of Charles L. Smith, 10 S. Arlington Ave. I made a mistake in the middle initial. Writing Charles F. Smith, when it should have been Charles L. Smith.

Very truly yours.

J. Chas. Norton, M.D.

...arr-
..." is
...ant
...onic
...itis;
...nt)
...Ex-
...ds.;
...re-
...l as
...ro-
...De-
...sy,"
...In-
...re-
...can
...all
..., as
...es,"
...was
...OF
...Mi-
...ter-
...ng;
...and
...]—
...ac-
...ste-
...bu-
...or-
...ies,
...ns,
...s,
...s,

disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64197. Secret Mt. Ave. CERTIFICATE OF DEATH. 90 D 64197.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 E. Fairmount Ave ST., 6 WARD)

2-FULL NAME Josephine Braitenbach.

(a) RESIDENCE NO. 2125 E. Fairmount Ave ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Caspar Braitenbach

6 DATE OF BIRTH (month, day, and year) Jan. 27 1844

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF ~~FATHER~~ Hartman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mullmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie Lang (Daughter)
(Address) 2125 E. Fairmount Ave

15 Filed MAY 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1920 to May 11, 1922

that I last saw her alive on May 10, 1922

and that death occurred, on the date stated above, at 6 40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Regurgitation

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Senile Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

(Address) 000 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 15 1922

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE INFORMATION given below should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64198

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

STILL BIRTH No. D 64198

1 PLACE OF DEATH

Registered No. C .....

CITY OF BALTIMORE (No. 2572 Wilkins Ave St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Infant of Mrs Jesse Shanken

(Residence in Baltimore: No. 2572 Wilkins Ave St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	

6 DATE OF BIRTH May (Month) 10 (Day), 1922 (Year)

7 AGE 6 months postalum yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or 2 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9 BIRTHPLACE (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herbert M. Schanken

11 BIRTHPLACE OF FATHER (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jessie Pearl Stevens

13 BIRTHPLACE OF MOTHER (State or country) Cumberland Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Schanken

(Address) 2572 Wilkins Ave

15 MAY 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 10 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,

that I saw h..... alive on ....., 191...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: unknown

probably due to malarial attack of mother who is now convalescent

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Sutton M. D.

May 12, 1922 (Address) 505 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Western Cemetery | DATE OF BURIAL May 11, 1922

20 UNDERTAKER Geo J Smith | ADDRESS 1000 Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Premature Birth

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Barling)

D 64199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-DD 64199

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 E. 30th ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward G. Barling

(a) RESIDENCE. No. 2003 E. 30th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian J. Barling

6 DATE OF BIRTH (month, day, and year) Aug. 10th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R.R.Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward G. Barling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mrs. E. G. Barling (Address) 2003 E. 30th St.

15 Filed MAY 12 1922 J. E. Mehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 20th, 1921, to May 10th, 1922

that I last saw h[illegible] alive on May 9th, 1922

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

General Debility

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Empyema

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 1-1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D

. 19 (Address) 340 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 12 1922

20 UNDERTAKER C. D. Fanning & Son - 1460 ADDRESS Battery Av.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Result of
Lobar Pneumonia

6 / 31 / 1
15
2261

Spec.—1-10-21—M&T—1500 Bks.

D 64200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64200

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones.

(a) RESIDENCE NO. 502 Walnut ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 4, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ooo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Lavinia Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Reads

15 MAY 1 2 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1922 to Apr. 10, 1922 that I last saw her alive on Apr. 10, 1922 and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. H. Cathrall, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

MAY 12 1922

N. B.—WHITE PAPER, WITH CARBON. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Gray) ✓

D 64201

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 64201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1157 Whitelock ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gray

(a) RESIDENCE NO. 1157 Whitelock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Edward Gray

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Bertha Bowsletter

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Edward Gray

(Address) 1157 Whitelock St.

15 Filed MAY 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1922

17

I HEREBY CERTIFY, That I attended deceased from May 10th, 1922, to May 11th, 1922, that I last saw h— alive on May 10th, 1922, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

0091

4

(duration) yrs. mos ds.

CONTRIBUTORY ✓

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Jos Ellis, M. D.

, 19 (Address) 924 Mad ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loud Cemetery — DATE OF BURIAL May 13 1922

20 UNDERTAKER John R Owens — ADDRESS 5-38 Dolphin Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE SHOULD BE FILLED OUT IN THE REGISTRAR'S OFFICE. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Result of
Lobar Pneumonia

6151
25
2261

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 64202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64202

91-002

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 N. Fremont ave ST.: 17 WARD)

2-FULL NAME George M Sheckles

(a) RESIDENCE. No. 721 N. Fremont ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Algernia A Sheckles

6 DATE OF BIRTH (month, day, and year) June 11 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Clerk

(b) General nature of industry, business, or establishment in whlch employed (or emplover): City Courts

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Horace Scheckles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Amanda Colay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick County Md

14 Informant Algernia A Sheckles

(Address) 721 N. Fremont ave

15 Filed MAY 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 11. 1922

17

I HEREBY CERTIFY, That I attended deceased from 4. 1. 1922. to date of death that I last saw him alive on 5. 11. 1922, and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Due to Pontine Spinal Sclerosis of Thirty years duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Sclerosis Intestinal (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Percy Lee Lewis M. D.

, 19 (Address) 824 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 15 1922
20 UNDERTAKER Adolph M. Walker	ADDRESS 723 N. Lafayette ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64203

CERTIFICATE OF DEATH.

114 D 64203

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 571 Dolphin Street ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Carroll Chambers

(a) RESIDENCE. No. 571 Dolphin Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs XXX mos. XXX ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Dec.3rd.1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work XXXXXXX

(b) General nature of industry, business, or establishment in which employed (or employer) XXXXXXX

(c) Name of employer XXXXXXX

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pennsylvania

PARENTS

10 NAME OF FATHER Leon R.Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co. Maryland

12 MAIDEN NAME OF MOTHER Hester A.Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Maryland

14 Informant Leon R.Chambers.
(Address) 571 Dolphin Street

15 MAY 12 1922 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10 1922

17 I HEREBY CERTIFY, That I attended deceased from One day, 19, to May 10th., 19 22.
that I last saw him alive on May 10th., 19 22.
and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Uncertain- Convulsions, probably caused by an Acute Gastro-enteritis and Chronic Tonsillitis, was in a Comatose state when first seen by me.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Penn. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown Kent Co Md — DATE OF BURIAL: May 13 1922

20 UNDERTAKER: John H Owens — ADDRESS: 534 Dolphin

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Appollinaris A. Szczukowski.

D 64204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64204

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1700 Augusta ST. V WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Appollinaris A Szczukowski

(Residence in Baltimore No. 1700 Aliceanna St.; 39 yrs., 0 mos. 0 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word) husband

6-DATE OF BIRTH, Nov. (Month) 9 (Day), 82 (Year)

7-AGE, 45 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Ignatius Szczukowski.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Agnes Kilisz.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Szczukowska. Mother.

(Address) 1724 Aliceanna St.

15- MAY 12 1922 191.. ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 11 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

Probably Tuberculosis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] (Coroner.)

May 12, 1922 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, May 15, 1922

20-UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64205

D 64205

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Barnes St ST., 7 WARD)

2-FULL NAME Anna Kapralek

(a) RESIDENCE NO. 1627 Barnes ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 45 yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Kapralek

6 DATE OF BIRTH (month, day, and year): May 28-1851

7 AGE — Years: 71 — Months: 11 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): — 000

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Bohemia Europe

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia - Europ

12 MAIDEN NAME OF MOTHER: Rosi Jurousek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia Europe

14 Informant: Sophie Ceske
(Address): 1627 Burner St

15 Filed MAY 12 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1922

17 I HEREBY CERTIFY that I attended deceased from April 1 1922 to May 11 1922

that I last saw h alive on May 11 1922

and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. ... mos. ... ds.

General dropsy

CONTRIBUTORY (Secondary)

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Carles N. A. Meyer M. D.

5/11, 1922 (Address) 1031 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill Holy Redeem — DATE OF BURIAL: May 13 1922

20 UNDERTAKER: Burkler & Burkler — ADDRESS 1739 Eager

D 64206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001.

D 64206

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Standard Oil Co. Plant 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Christopher Branagan

(Residence in Baltimore: No. 1224 S. Clinton St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. (Month) 31 (Day), 1873 (Year)

7-AGE. 48 yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Oil

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Christopher Branagan

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Ann Riley

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Branagan

(Address) 1224 S. Clinton St.

15- Filed MAY 12 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Gas

Entrance (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.
(Coroner)

May 12th 1922 (Date) Curtis Bay, Md. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, St Patrick's Cemetery

DATE OF BURIAL, May 13, 1922

20-UNDERTAKER Zinkler + Zinkler

ADDRESS 1739 E. Eager St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Accident.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Broncho-pneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Herckenrother

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64207

CERTIFICATE OF DEATH.

181 D 64207

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Standard Oil Co. Lab (WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Herckenrother

(Residence in Baltimore: No. 3802 Fernwood Ave St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should WRITE PLAINLY, WITH UNFADING INK. This CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Apr. (Month) 2 (Day), 1894 (Year)

7-AGE: 28 yrs. 2 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Asst. Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Heating Plant

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Lawrence Herckenrother

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arabelle Herckenrother

(Address) 3802 Fernwood Ave.

15- Filed MAY 12 1922, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May (Month) 10th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Gas

(Duration) Accident yrs. mos. ds.

CONTRIBUTORY (Secondary) Duration yrs. mos. ds.

(Signed) Thos. B. Fortune M. D.
(Coroner)

May 12 1922 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oaklawn Cemetery

DATE OF BURIAL: May 14, 1922

20-UNDERTAKER: Zinkler + Zinkler

ADDRESS: 1739 E. Eager St.

Accident

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

See affadisit over ✓

D 64208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 64208

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

2-FULL NAME ~~William Riddle~~ (Frederick Riedel)

(a) RESIDENCE NO. 901 S. 6th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): apr. 29 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	--	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia, Pennsylvania

PARENTS

10 NAME OF FATHER: Frederick Riddle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records.

(Address): Municipal Hospital.

15 Filed MAY 12 1922 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 11, 1922,

that I last saw h im alive on May 11, 1922,

and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension & Cerebral Hemorrhage

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

5/11/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: May 14 1922

20 UNDERTAKER: Zinkler & Zinkler — ADDRESS: 1739 E. Eager St.

Baltimore, Md., June 15th. 1922.

TO WHOM IT MAY CONCERN :-

This is to certify that Fredreick Riedel of 901 S. 6th. St Baltimore, Md., was admitted to the Municipal Hospital of Baltimore City on May 4th.1922 under the name of William Riddle through an error in not getting his name correct, and he since has died on May 11th.1922 at this Hospital. So this is the cause of giving his incorrect name to the Health Department at his death.

Thomas. N. Magness M.D.
14. East. Read. St.

Subscribed and sworn to before me this 15th. day of June, 1922.

Mary. J. Lehmann.
NOTARY PUBLIC.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64209

CERTIFICATE OF DEATH.

113 D 64209

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 619 Dennison St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. Keane

(Residence in Baltimore: No. 619 Dennison St.; yrs., mos. 14 ds.)

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, April 28, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Chas. F. Keane

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Evelyn Sharack

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. Keane

(Address) 619 Dennison St.

15-

Filed ....., 191....

Robert P. Harrison,

MY 12 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro Enteritis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. F. Hennessy M. D.
(Coroner.)

May 12, 1922 (Address) 2702 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Forrest Cemetery	May 12 1922
20-UNDERTAKER Geo J Smith	ADDRESS 1000 Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64210

CERTIFICATE OF DEATH.

135 D 64210

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Samuel R Vickers

(a) RESIDENCE. NO. Belvidere Hotel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	"	"	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Vickers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Wilmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mercy Hospital Records

(Address)

15 MAY 12 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1921 to May 12, 1922

that I last saw h[illegible] alive on May 12, 1922

and that death occurred, on the date stated above, at 5:45 p. m.

The CAUSE OF DEATH was as follows:

Benign Prostatic Hypertrophy, Cystitis, Epididymitis, Orchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Finding of Physical Signs & Symptoms

(Signed) John C Ehrich, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL May 17 1922

20 UNDERTAKER Henry Jenkins & Son

ADDRESS Enclosed

B.—WRITE PLAINLY, with ink, and be careful to see that all items are correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that all items are correctly supplied. Exact statement of OCCUPATION should be carefully

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Hunting)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64212

CERTIFICATE OF DEATH.

45 D 64212

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 W. 25th St.: 17 Ward)

2-FULL NAME George B. Hunting

(a) RESIDENCE. No. 34 W. 25th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed,~~ or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Alice E. Hunting

6 DATE OF BIRTH (month, day, and year) 1839-12-15

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Boston (State or country) Mass.

PARENTS

10 NAME OF FATHER Daniel F. Hunting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Caroline W. Belknap

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mrs. Alice E. Hunting (Address) 34-25 St West.

15 Filed MAY 12 1922 Robert P. Harrison, Registrar

D. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from 1920, to May 11, 1922, that I last saw h. alive on May 11, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Frank H. Smith, M. D.

5/11, 1922 (Address) 2438 Mary Land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	5/13 1922
20 UNDERTAKER Swingley Funeral Home Co	ADDRESS Walbrook Orchard

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64212

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2120 S. Charles ST., 17 WARD)

2-FULL NAME Ida Parthenia Meyer

(a) RESIDENCE NO. 2120 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Henry Meyer

6 DATE OF BIRTH (month, day, and year) June 18 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co. Md (State or country)

PARENTS

10 NAME OF FATHER Edward Rollison

11 BIRTHPLACE OF FATHER (city or town) Kent Co (State or country) Md

12 MAIDEN NAME OF MOTHER Isabel Simpson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mabel Broughton (Address) 410-15 Balto Md.

Filed May 12 1922 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922 to May 10, 1922

that I last saw h alive on May 10, 1922

and that death occurred, on the date stated above, at 6 40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinically

(Signed) H. R. Campbell M. D.

May 12, 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery DATE OF BURIAL May 13 1922

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64213

CERTIFICATE OF DEATH.

D 64213

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 Carrollton Ave WARD 16)

2-FULL NAME George Warfield

(a) RESIDENCE. NO. 624 Carrollton Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Warfield

6 DATE OF BIRTH (month, day, and year) Jan 23 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Sheckells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jimmie C. Price (Address) 624 N. Carrollton Ave

15 Filed 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3rd 1922 to May 11th 1922, that I last saw him alive on May 11th 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Fatal Arteriosclerosis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Hanbell Williams M. D.

, 19 (Address) 901 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 15 1922
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St.

B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

W 12

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64214 HEALTH DEPARTMENT—CITY OF BALTIMORE 64214

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 W. Mosher ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. M. Trainer

(a) RESIDENCE. NO. 307 W. Mosher ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 6 mos. ? ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Nov. ? 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	6	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Trainer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah Trainor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Hannah E. Trainer
(Address) 307 W. Mosher Street

15 Filed 19 Robert F. Harrison, Registrar
Burial Permit Clerk

MAY 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922 to May 10, 1922 that I last saw her alive on May 10, 1922 and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis unknown. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) Mary F. Coglan M. D.

19 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 5/14, 1922

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

X. E.—WRITE PLAINLY, with unfading ink. All items must be answered or the word "unknown" or the proper word indicating that the information is not obtainable, inserted. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64215 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64215

CERTIFICATE OF DEATH. REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 18-003 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lemuel Dean

(Residence in Baltimore: No. ~~2420~~ 11 Maryland. 9 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 27 (Day), 1852 (Year)

7-AGE, 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Seamstress (b) General nature of industry, business, or establishment in which employed (or employer) 169

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER Richard Dean.

11-BIRTHPLACE OF FATHER (State or Country) Balto.

12-MAIDEN NAME OF MOTHER Martha Dunn

13-BIRTHPLACE OF MOTHER (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. Dean

(Address) 25 N Maryland Ave

15-

Filed ... Robert P. Harrison, ... Registrar.

MAY 12 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, accidentally Struck by auto May 10 -

2 hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

May 12 1922 (Address) 1059 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State 2 hrs yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery DATE OF BURIAL, May 13 1922

20-UNDERTAKER E. A. Wiedefeld Jr ADDRESS 501 E 22nd St

8

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64216

D 64216

CERTIFICATE OF DEATH.

#5

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nellie Carl

(a) RESIDENCE. NO. 9 Strathmore Ave ST., WARD.
(Usual place of abode) Hamilton (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. W. Carl

6 DATE OF BIRTH (month, day, and year): Sept 6th 1852

7 AGE: Years 70 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(g) Trade, profession or particular kind of work: Housewife 037

(h) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Monroe Co Pa.

PARENTS

10 NAME OF FATHER: Mr Frankenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Julia Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Hospital records

15 Filed , 19 Registrar

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1922

17

I HEREBY CERTIFY, That I attended deceased from April 30th, 1922, to 5-12-, 1922,

that I last saw h alive on 5-11-, 1922,

and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 6-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S H Culver, M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: May 14 1922

20 UNDERTAKER: E. LeRoy Stiffler — ADDRESS: 1252 North

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS and information should be carefully supplied. AGE should be given in every case. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(See affidavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64217.

CERTIFICATE OF DEATH.

87-4-001 D 64217

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1115 N Milton ave St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Boland

(Residence in Baltimore: No. 1115 N Milton Ave St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, February 1, 1842.
(Month) (Day) (Year)

7-AGE, ~~88~~ 73. 3. 10
~~88~~ yrs. ~~3~~ mos. ~~11~~ ds.

If ~~LESS~~ than 1 day, ...hrs. or.... ~~min.~~?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Burns

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Glohster

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Mrs Cooper

(Address) 1115 N Milton Ave

15-

Filed ....., 191.....

Registrar.

N. B.—Every item of information must be given, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

BY [illegible] 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 1917, to May 11 1917, that I saw h[illegible] alive on May 10 1917, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

May 12, 1917 (Address) 3017 Pat Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Charles Cemetery

DATE OF BURIAL, 5/13 ....., 1917

20-UNDERTAKER George J Ruth

ADDRESS 1735 Harford Av

Baltimore, Md., May 19, 1922.

I do hereby make oath that the age of deceased, Bridget Boland, given on Baltimore City Health Department Certificate of Death D-64217 as 80 years, 3 mos., 11 days, and the date of birth given as February 1, 1842, is not correct; same should be recorded as - date of birth - February 1, 1849 and the age as 73 years, 3 mos., 10 days.

Thos S Mas.

Daughter.

Subscribed and sworn to before me this 19th day of May, 1922.

Fred Gaither

Notary Public.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64218

CERTIFICATE OF DEATH.

90

D 64218

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 15 WARD)

2-FULL NAME James Brown

(a) RESIDENCE NO. 1503 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	--	--	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co., (State or country) Maryland

PARENTS

10 NAME OF FATHER Johns Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records.

(Address) Municipal Hospital.

15 Robert P. Harrison, Registrar

MAY 12 1922

Burial Permit Clerk.

B.—WRITE PLAINLY. ... should be carefully supplied. ... mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to May 10, 1922, that I last saw him alive on May 10, 1922 and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1503 N Stricker

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde McNeill M. D.

5/10/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 14th 1922

20 UNDERTAKER A Jones

ADDRESS 207 S. Stricker St

Spec.—1-10-21—M&T—1500 Bks.

10-4890

D 64219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64219

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. " " " ST., 9 WARD)

2-FULL NAME Liona O'Neil

(a) RESIDENCE NO. New Freedom, Pa. (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Harry F. O'Neil

6 DATE OF BIRTH (month, day, and year) Sept. 4-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	8	8	

8 OCCUPATION OF DECEASED ?

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John ? Wilderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth ? Kenimeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Robert P. Harrison, Registrar

MAY 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1922 to May 12, 1922, that I last saw her alive on May 12, 1922, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Glioma

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 1 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Pa

DATE OF BURIAL May 13th 1922

20 UNDERTAKER A. Jones

ADDRESS 207 S. Strieker St

B.—WRITE PLAINLY. Ages, dates and places must be carefully supplied. All information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64220

D 64220

CERTIFICATE OF DEATH.

REGISTERED NO. C 3129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 Lancaster ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalia Olszewski

(Residence in Baltimore: No. 1522 Lancaster St. St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. 24 (Month) (Day), 1862 (Year)

7-AGE, 59 yrs. 8 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country), Bezenwalde West Prussia Germany

PARENTS.

10-NAME OF FATHER, John Jegiesski

11-BIRTHPLACE OF FATHER (State or Country) Bezenwalde West Prussia Germany

12-MAIDEN NAME OF MOTHER Catherine Szymkowski

13-BIRTHPLACE OF MOTHER (State or Country), Widersi West Prussia Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Jegiesski

(Address) 1230 Lancaster St.

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

MAY 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 8 1922, to May 11 1922, that I saw her alive on May 10 1922, and that death occurred, on the date stated above, at 5.11P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Exhaustion

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Attended to Brodrick M. D.

May 11 1922 (Address) 5 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL. 5/13 1922

20-UNDERTAKER William Fiaelkowski — ADDRESS 1618 Eastern Ave

B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64221

CERTIFICATE OF DEATH.

31 D 64221

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 Eutaw Place ST., 14 WARD)

2-FULL NAME Dr. Clarence Warfield

(a) RESIDENCE NO. 2031 Eutaw Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of Industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lancelot Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Burd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. D. H. McCafferty (Address) 705 Newington Ave

15 MAY 12 1922 .19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25 .1922 to May 10 .1922

that I last saw him alive on May 10 .1922

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 mos

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) E. B. Friedman M. D.

(Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millerwell Md

DATE OF BURIAL May 13 1922

20 UNDERTAKER W. M. Fickus Sons

ADDRESS Norfolk Va

B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. AGE should be properly classified. Exact statement of information should be carefully supplied, so that it may be properly classified. Exact statements may be made in plain terms, so that it may be properly classified. Exact statements may be made in plain terms, so that it may be properly classified. Exact statements may be made in plain terms

Spec.—1-10-21—M&T—1500 Blks.

D 64222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64222

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 Elsinore ST., 15 WARD)

2—FULL NAME Emmett L Chase

(a) RESIDENCE NO. 2810 Elsmore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roberta Chase

6 DATE OF BIRTH (month, day, and year) 31-Aug-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secty to 009

(b) General nature of Industry, business, or establishment in which employed (or employer) Brewmaster

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Simon L Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Whitman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Whitman

14 Informant Roberta Chase

(Address) 2810 Elsmore

15 Filed ..... 19 ..... Registrar

1922 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1922, to May 11th, 1922.

that I last saw him alive on May 11th, 1922,

and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Uraemia (duration) — yrs. — mos one ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary.

(Signed) Stelwa F Stellman, M. D.

, 19 (Address) 1227 W Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Rec'd May 13 22 DATE OF BURIAL 19

20 UNDERTAKER Wm J Schnerr & Son ADDRESS North Ave

N. B.—WRITE PLAINLY, with ink. AGE should be carefully supplied. Exact statement of information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64223

CERTIFICATE OF DEATH.

D 64223

101

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 774 W. Cross ST., 21 WARD)

2-FULL NAME Rebecca Gable

(a) RESIDENCE NO. 774 W. Cross ST., ... WARD .....

(Usual place of abode) Life (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Gable

6 DATE OF BIRTH (month, day, and year) Dec 9 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	48	5	2	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank Recker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Christina Lowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mr. John Gable 774 W. Cross St.

15 Robert P. Harrison, Registrar

MAY 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to May 11, 1922, that I last saw h alive on May 11, 1922, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinically

What test confirmed diagnosis? .....

(Signed) H. L. Campbell M. D.

May 12, 1922 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL May 15 1922.

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca St.

B.—WRITE PLAINLY. Age should be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 64224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64224

CERTIFICATE OF DEATH.

671-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S. Seventh ST., 76 WARD)

2-FULL NAME Leo Lorenzo

(a) RESIDENCE NO. 231 S. Seventh ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) April 5, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	2	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Angelo Lorenzo

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John Lorenzo (Address) 231 S. 7th St.

15 Filed ..... 19..... Registrar

MAY 1 8 1922 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 10, 1922, that I last saw him alive on May 10, 1922, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus peritonitis

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumococcus Meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Meningitis developed in Johns Hopkins Hospital

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture

(Signed) J. H. Mc Cosh, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 5/13/22

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Harford Ave.

N. B.—WRITE plainly and carefully supplied. Infor- mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64225 ✓ 37 D 64225

CERTIFICATE OF DEATH.

D 64225

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Over

(a) RESIDENCE. NO. 3618 Eastern ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

040

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Over

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Shaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

19 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1921, to May 12, 1922

that I last saw him alive on May 12, 1922

and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Badaglucco M. D.

5-12-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL 5/13/22

20 UNDERTAKER Geo. J. Rutt ADDRESS 1735 Eutaw

INFORMATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. ITION is very important.

A 12 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64226

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4th Ave - Fairfield. ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Mc Neily

(a) RESIDENCE. NO. 4th Ave. Fairfield ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	infant

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfield Md.

PARENTS

10 NAME OF FATHER Ely Mc Neily

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Maggie Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Maggie Mc Neily
(Address) 4st. Fairfield

15 Filed 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 10, 1922, that I last saw her alive on May 10, 1922, and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Premature
Con

(duration) yrs. 3 mos. 5 ds.

CONTRIBUTORY (Secondary) Congenital Lues.

(duration) yrs. 3 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History, sign & symptom -

(Signed) Geo. E. Wells. M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	May 13 1922
20 UNDERTAKER	ADDRESS
John H. Toadvine	142 Utica St

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

MAY 1

Spec.—6-9-19—H. P. Co.—1000 Bks.

Musical

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64227

CERTIFICATE OF DEATH.

101 D 64227

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 525 S Washington ST.; 2 WARD)

2-FULL NAME Frank Musial

(a) RESIDENCE. NO. 525 S Washington ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Musial

6 DATE OF BIRTH (month, day, and year) May 5 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Long Shoreman

(b) General nature of industry, business, or establishment in which employed (or employer) C&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Steve Musial (Address) 525 S Washington

15 Filed MAY 13 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/4 1922 to 5/12 1922, that I last saw h[illegible] alive on 5/11 1922, and that death occurred, on the date stated above, at 220 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym & Symptoms

(Signed) Thos D Mulleyd, M. D.

5/12 1922 (Address) 1625 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 15 1922
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

B—[illegible] should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64228

CERTIFICATE OF DEATH.

31

D 64228

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 S Bonnet ST.: 1 WARD)

2-FULL NAME Joseph Stefanski

(a) RESIDENCE. NO. 1121 S Bonnet ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Stefanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Magdalena Wielinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Richard Stefanski
(Address) 1121 S Bonnet

15 [illegible] Robert P. Harrison, Registrar

MAY 13 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3 1922, to May 11 1922, that I last saw him alive on May 10 1922, and that death occurred, on the date stated above, at 8300 m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chas O Neer M. D.

3/17/22 19 (Address) 408 S Pat PK ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 13 1922

20 UNDERTAKER John M Weber ADDRESS 1803 Bank

B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64229

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64229

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 S Dallas ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Elliott

(a) RESIDENCE. NO. 132 S. Dallas ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? ? 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Making clothes

(c) Name of employer Chinese Laundry Pratt & Dallas sts

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Aaron Cooper (Address) 132 S. Dallas st

15 Filed MAY 13 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/22 19

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1922, to May 10, 1922, that I last saw her alive on May 10 —, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Acute dilatation of heart

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Marcellus E. Toney, M. D.

19 (Address) 1449 N Carey st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	May 13 1922
20 UNDERTAKER John W Henderson	ADDRESS 1502 E monument

B—Blanks should be carefully supplied. All items should be properly classified. Exact information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64230

D 64230

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brown

(a) RESIDENCE NO. 415 N. Caroline St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co., Maryland

10 NAME OF FATHER Tom Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Maryland

12 MAIDEN NAME OF MOTHER Eliza Holton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Maryland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed MAY 13 1922, 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 10, 19 22, to May 11, 19 22, that I last saw her alive on May 10, 19 22, and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilitic aortic insufficiency (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Negative endocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Mondell, M. D.

5/13/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL May 14 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

B.—WRITE PLAINLY. All items should be carefully supplied. Any information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64231

CERTIFICATE OF DEATH.

D 64231

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W Lanvale ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Fitz Hugh.

(a) RESIDENCE NO. 702 W Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colord | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown 1853

7 AGE 69 Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nellie Sheridan

(Address) 702 W Lanvale st

15 Filed MAY 1 1922, 19

Robert F. Harrison,

Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to May 11, 1922,

that I last saw h alive on May 11, 1922,

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Infected Knee joint (Left)

(duration) 2 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Endocarditis. (Ulcerative)

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? 1517 Bolton St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) R B Stevenson M. D.

5/12. 19 22 (Address) 609 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Port Cathedral Cemetery | DATE OF BURIAL May 15 - 19 22

20 UNDERTAKER Mrs Robert A Elliott | ADDRESS 1725 Ashland Ave

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 64232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64232

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

2-FULL NAME Joseph H. Parr

(a) RESIDENCE. NO. Mt Hope Retreat ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Parr

6 DATE OF BIRTH (month, day, and year) Aug 30- 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	8	02	

8 OCCUPATION OF DECEASER

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Clothes —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Parr

11 BIRTHPLACE OF FATHER (city or town) (?)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Bush

13 BIRTHPLACE OF MOTHER (city or town) (?)

(State or country) Germany

14 Informant Records of Mt Hope Retreat

(Address) Baltimore Md

15 Filed ....., 19 ..... Registrar

MAY 13 1922

Robert P. Harrison, Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28th, 1921, to May 12, 1922, that I last saw him alive on May 11th, 1922, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Paresis - Specif -

Duration (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? — W. Dash

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 15 1922
20 UNDERTAKER	ADDRESS
Henry Hoech Son	130 E Eager St

N. B.—Blanks should be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64233 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64233

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2712 Penn. Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maximilian Spitznagel

(Residence in Baltimore: No. 2712 Penn. Ave St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	W	Married

6-DATE OF BIRTH, Oct (Month) 7 (Day), 1865 (Year)

7-AGE, 57 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Restaurant
(b) General nature of industry, business, or establishment in which employed (or employer): Proprietor

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Leopold Spitznagel

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Lillie Berzner

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Spitznagel

(Address) 2712 Penn. ave

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 11 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 7 1922, to May 11 1922, that I saw h-- alive on May 11 1922, and that death occurred, on the date stated above, at 1025 m.

The CAUSE OF DEATH* was as follows:

1. Cerebral Hem.
Liver
(Duration) one year yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver
(Duration) yrs. mos. 2 ds.

(Signed) Fred C. Jennett M. D.

May 12 1922 (Address) 2.5.7 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, May 16. 1922

20-UNDERTAKER Josiah Dyer — ADDRESS 1600 Pennsylvania Ave

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

MAY 13 1922

Spec.—6-9-19—H. P Co.—1000 Bks.

D 64234

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 64234

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Myrtle Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Larkins Jr.

(a) RESIDENCE. NO. 1229 Myrtle Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltor

PARENTS

10 NAME OF FATHER Jas H. Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Rochfort

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) Cecelia Bennett 1229 Myrtle Ave

15 Filed ..... 19 ..... Registrar Robert P. Harrison,

Burial Permit Clerk.

MAY 11 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11" 1922

17 I HEREBY CERTIFY, That I attended deceased from April 5 1922, to May 11 1922, that I last saw him alive on May 10 1922, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. K. Hemmeter, M. D.

(Address) 500 Harlem Av

May 11, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cem.	5/15" 1922

20 UNDERTAKER Chas F. Evans & Son ADDRESS 1180 Mont. Road

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms; so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64235

CERTIFICATE OF DEATH.

1529 D 64235

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 N Ellwood Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward V. Johnson

(Residence in Baltimore: No. 216 N Ellwood Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	—

6-DATE OF BIRTH, May 12 (Month) 12 (Day) 1922 (Year)

7-AGE, — yrs. .... mos. .... ds. If LESS than 1 day, ½ hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), 216 N Ellwood Ave

PARENTS.

10-NAME OF FATHER. Edward Johnson

11-BIRTHPLACE OF FATHER (State or Country), Cumberland Md

12-MAIDEN NAME OF MOTHER Mary Keagen

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Johnson

(Address) 216 N. Ellwood Ave

15- Robert P. Harrison, ... 191.... Registrar.

MAY 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 191.... , to .... 191....,

that I saw h.. alive on May 12 1922, and that death occurred, on the date stated above, at 7 P.M. m.

The CAUSE OF DEATH* was as follows: Blue Baby (Natal) Coma (Cyan.)

.... (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) .... (Duration) .... yrs. .... mos. .... ds.

(Signed) Dr Kelly M. D.

May 12, 1922 (Address) 1603 N. Linwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 5/13, 1922

UNDERTAKER Chas. P. Crane & Son ADDRESS 1118 W. Royal Ave

Every item of information must be given, so that if any of the particulars called for by CAUSE OF DEATH in plain terms, so that if any of the particulars called for by this certificate are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64236

33 D 64236

CERTIFICATE OF DEATH.

D 64236

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard E. Potts.

(a) RESIDENCE. NO. 658 Gutman ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 18. 1881

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
40	8	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John F. Potts.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Estelle Hager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Mrs John Kirkman 658 Gutman ave

15 Filed MAY 19 1922 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11. 1922

17 I HEREBY CERTIFY, That I attended deceased from March 2., 1922, to May 11., 1922.

that I last saw h.. alive on May 11., 1922

and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Tubercular fistulae with ulceration of Colon.

(duration) yrs. 2 mes. 11 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 658 Gutman ave

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John O'Meara, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bulls Cessna

DATE OF BURIAL May 13 1922

20 UNDERTAKER Sherwood & Son

ADDRESS Chestnut ave

mation should be given in these columns, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64237

CERTIFICATE OF DEATH.

REGISTERED NO. 11 3

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 808 N. Glover ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy R. Lehmeyer.

(a) RESIDENCE NO. 808 N Glover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 6 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 5/1921

7 AGE — Years: — Months: 6 Days: 7

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frederick Lehmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Anna Beckmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Frederick Lehmeyer

(Address): 808 N. Glover.

15 Filed MAY 13 1922 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/13 ....., 19 22, to 5/12 ....., 19 22,

that I last saw h alive on 5/12 ....., 19 22,

and that death occurred, on the date stated above, at 2:20 m.

The CAUSE OF DEATH* was as follows:

Acute Heart Trouble

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Colitis Entero

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. E. Meyer, M. D.

5/13 19 22 (Address) 2336 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: May 15 1922

20 UNDERTAKER: J Ullrich

ADDRESS: 2008 Aliceanna

Information should be carefully supplied, so that it may be properly CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 64238

CERTIFICATE OF DEATH.

D 64238

REGISTERED NO. 8 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 E Hoffman ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Doroschky

(a) RESIDENCE. NO. 2630 E Hoffman ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs — mos. — ds. How long in U. S., if of foreign birth? 55 yrs — mos — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Doroschky

6 DATE OF BIRTH (month, day, and year) June 12 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian Doroschky (Address) 2630 E Hoffman

15 Filed Robert F. Harrison, Registrar

MAY 13 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 11, 1922, that I last saw her alive on May 10, 1922, and that death occurred, on the date stated above, at 9.25 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

4 mos. 4 ds. (duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Gusta Simons M.D. M. D.

5/11/1922 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel May 14 1922

20 UNDERTAKER Philip Henrig ADDRESS 2016 Orleans

mation should be given in plain terms, so that it may be properly classified. Certificates of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 64239 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D 64239

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 600 N. Chapel St. 6 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael A. Stern (If LESS than 1 day, hrs. or min.) mos. ds.)

(Residence in Baltimore: No. 227 N. Chapel Street)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE. White
5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. Jan (Month) 2 (Day) 1869 (Year)

7-AGE. 53 yrs. 4 mos. ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Oil

9-BIRTHPLACE. (State or Country) Baltimore Md

PARENTS.
10-NAME OF FATHER. Peter Stern
11-BIRTHPLACE OF FATHER. (State or Country) Germany
12-MAIDEN NAME OF MOTHER. Mary Mackley
13-BIRTHPLACE OF MOTHER. (State or Country) Germany

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter A. Stern
(Address) 510 S. 13 St

15- Filed 1922 Robert F. Harrison, 192.... Registrar.

Nurses Instly 2738 E. Baltimore St

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May (Month) 11 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia Influenza
Probably Tuberculosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. Winfield Smith M. D.
(Coroner.)
5-12 1922. (Address) 2511 E. Belvedere

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, May 15 1922

20-UNDERTAKER, William Lack ADDRESS 502 E North Ave

N. B.—Every item of information should be given in plain terms, so that it may be understood by persons not familiar with technical terms used in certificate. State CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with technical terms used in certificate. Is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64240

CERTIFICATE OF DEATH.

38D 64240

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 10 WARD)

2-FULL NAME Anna Sherwood

(a) RESIDENCE NO. 1435 Webb St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE — Years: ? 62 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed ....., 19..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MAY 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 5, 19 22 to May 11, 19 22

that I last saw h alive on May 11, 19 22

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal syphilis
(Meningo-vascular)

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes Aut. was the

What test confirmed diagnosis?

(Signed) Clyde McNeely M. D.

5/12/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Patricks Cem.

DATE OF BURIAL: May 13 1922

20 UNDERTAKER: Wm. F. Turner Inc.

ADDRESS 1442 Broadway

mation should be entered in plain terms, so that it may be properly CAUSE OF DEATH is very important. See instructions on back of certificates. TION

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 5 350.
D 64241

CERTIFICATE OF DEATH.

✓ 146 D 64241

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. " " ST., 7 WARD)

2-FULL NAME Mrs. Margorie Helene Harris.

(a) RESIDENCE NO. Shadow Drive, Miami, Florida
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David P. Harris (Husband)

6 DATE OF BIRTH (month, day, and year): Aug. 3, 1894.

7 AGE: Years 27 | Months 9 | Days 9 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Tenn.

PARENTS
10 NAME OF FATHER: Josiah D. Merritt.
11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.
12 MAIDEN NAME OF MOTHER: Helen Grange
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dominion of Canada.

14 Informant (Address): JOHNS HOPKINS HOSPITAL Florida

15 Filed ..... 19 ..... Registrar
MAY 1922 Robert F. Harrison, Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to May 12, 1922, that I last saw her alive on May 12, 1922 and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Post-operative hemorrhage.
Hemorrhage from wound of
Omentum & subcutaneous tissue.

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florida.
Did an operation precede death? Yes Date of May 11-1922
Was there an autopsy? No
What test confirmed diagnosis? Operation.

(Signed) K. H. Mahoney, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Miami Fla.
DATE OF BURIAL: 5-13 1922.

20 UNDERTAKER: Frazier W. Jenkins & Sons Co
ADDRESS: Wilkinson & Orchard

mation should be given in plain terms, so that it may be properly
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64242

CERTIFICATE OF DEATH.

90 D 64242

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Morton

(a) RESIDENCE NO. 509 Reed ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Morton

6 DATE OF BIRTH (month, day, and year) Nov 22 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maria Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mercy Hospital Records (Address)

15 MAY 13 22 H Helfrich Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 8, 1922 to May 12 1922 that I last saw him alive on May 12, 1922 and that death occurred, on the date stated above, at 4:52 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) 2 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Sign & Symptom

(Signed) John J. Crum M. D.

(Address) Mercy Hospital 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Auburn | DATE OF BURIAL 5-15 1922

20 UNDERTAKER George H. Holland | ADDRESS 1631 Druid Hill Ave

mation should be entered, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64243

D 64243

CERTIFICATE OF DEATH.

REGISTERED NO. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 352 Roseberry Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Stoumsky

(Residence in Baltimore: No. 352 Roseberry Ave St.: 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January (Month) 18 (Day) 1914 (Year)

7-AGE, 7 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER, Louis Stoumskey

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER Sarah E. Jackson

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Stoumskey

(Address) 352 Roseberry Ave

15-

Filed 1922 191... Harrison, Registrar.

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 11 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 1922, to May 11 1922, that I saw him alive on May 11 1922, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows: Intracranial Meningitis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo. H. Hocking M. D.

191... (Address) 5035 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Prospect Hill Cemetery

DATE OF BURIAL, May 14 191...

ADDRESS

20-UNDERTAKER F. B. Wehrheit & Son

ADDRESS 1701 Eden St

CAUSE OF DEATH in plain terms, and important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64244

CERTIFICATE OF DEATH.

REGISTERED NO. 24 74 D 64244

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 W. Hamburg ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Miller

(a) RESIDENCE. No. 217 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) [illegible] 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Elizabeth Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John F. Miller (Address) 2216 McCulloh St.

15 Filed MAY 13 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1922, to May 12th, 1922, that I last saw h[illegible] alive on May 11th, 1922, and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) .. yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) ? yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. H. Llewellyn, M. D.

5/12, 1922 (Address) 1400 Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	May 14 1922
20 UNDERTAKER	ADDRESS
Samuel Hemsley	Biddle

MAJOR CAUSE OF DEATH in plain terms, so that it may be grouped for statistics. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64245

CERTIFICATE OF DEATH.

90 D 64245

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Bloom ST. 14 WARD)

2-FULL NAME William B. Chew

(a) RESIDENCE. No. 521 Bloom ST. 14 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Richard L. Chew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Broad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Clara Ridgway (Address) 521 Bloom St

15 Filed MAY 13 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1922 to May-10-, 1922, that I last saw him alive on May-8-1922 and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 1432 Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL May 13 1922

20 UNDERTAKER Saml Weasley ADDRESS 37 Bolton

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. INFORMATION is very important.

MAY 13 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64246

CERTIFICATE OF DEATH.

D 64246

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 14 S. Stockton ST., 18 WARD)

2-FULL NAME Frank West

(a) RESIDENCE NO. 14 S. Stockton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Cora West

6 DATE OF BIRTH (month, day, and year): June 7, 1884

7 AGE — Years: 37 — Months: 11 — Days: 4 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Railway

(c) Name of employer: United Railways Elect Co

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md

PARENTS

10 NAME OF FATHER: Frank West

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince George Co Md

12 MAIDEN NAME OF MOTHER: Viola Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Prince George Co Md

14 Informant (Address): Samuel A. West 2140 Etherbin St

15 Robert F. Harrison, Registrar

MAY 13 1922 Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1922, to May 11, 1922, that I last saw him alive on May 10, 1922, and that death occurred, on the date stated above, at 12.35 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis

(duration) Indefinite ds.

CONTRIBUTORY (Secondary): Myocarditis (duration) Indefinite ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test ~~confirmed~~ diagnosis? .....

(Signed) W. H. Hoville M. D.

5/11/1922 (Address) 1171 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marks Harmony Cem.

DATE OF BURIAL: May 14 1922

20 UNDERTAKER: A. A. Co. Md Edward Ruggold

ADDRESS: 1462 Carey St

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64247

CERTIFICATE OF DEATH.

X 159-003

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester Lenard Caple

(a) RESIDENCE. NO. Patapsco Md ST., WARD. Patapsco. Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Patapsco
(State or country) Maryland

PARENTS

10 NAME OF FATHER Leslie Caple

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Marjorie Mann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant F Reed
(Address) Westminster Md

15 Filed . 19 Robert P. Harrison, Registrar

MAY 13 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13. 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 11. 1922. to May 13. 1922.

that I last saw h[illegible] alive on May 13. 1922.

and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Hare-lip and cleft palate.

(duration) 1 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 13, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John W Whitehead, M. D.

, 19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md

DATE OF BURIAL May 13 1922

20 UNDERTAKER H M Routson

ADDRESS 230 N Green

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64248

D 64248

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 E Hughes St ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Gonic

(a) RESIDENCE NO. 32 E. Hughes St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) March 21, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) 870

(c) Name of employer None Balto., Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Charles Gonic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Clara Thomas

13 BIRTHPLACE OF MOTHER (city or town) Calvert (State or country) County Md.

14 Informant Clara Thomas (Address) 22 E. Hughes St

15 Robert P. Harrison, Registrar

MAY 13 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11- 1922

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1922, to May 11 - 1922, that I last saw her alive on May 11- 1922, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy Leakage of Heart + Bright's Disease (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Leakage of Heart Bright's Disease + Complication (duration) yrs. 5 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr W Kennard, M. D.

5-12, 1922 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL 5/14 1922

20 UNDERTAKER Robt. L. Parham ADDRESS 642 W Lexington St

CAUSE OF DEATH in plain words. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64249

CERTIFICATE OF DEATH.

46 D 64249

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3200 Garrison ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace V. Hanigan

(a) RESIDENCE NO. 3200 Garrison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip A Hanigan

6 DATE OF BIRTH (month, day, and year) Sept 5th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berkleyville Balto Co Md

PARENTS

10 NAME OF FATHER Joseph Waltemyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stewartstown Pa

12 MAIDEN NAME OF MOTHER Keziah Royston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Philip A Hanigan (Address) 3200 Garrison ave

15 MAY 13 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1922, to May 12, 1922, that I last saw h~~er~~ alive on May 12, 1922 and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma mesenteric glands- following malignancy of uterus (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of mesenteric glands (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ~~No~~ Yes Date of Nov 13/1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hall S. Nesbit M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 15th 1922
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Information should be carefully supplied, so that it may be properly recorded in all future certificates. CAUSE OF DEATH in plain terms, so that it may be properly recorded in all future certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

155786 64250

HEALTH DEPARTMENT—CITY OF BALTIMORE

64250

CERTIFICATE OF DEATH.

D 64250

REGISTERED NO.

1-PLACE OF DEATH D 64250

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Lois P. Hill. Roanoke Va.

(a) RESIDENCE. No. 610 Campbell Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Charles P. Hill Father

6 DATE OF BIRTH (month, day, and year) Feb 27, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles E. Hill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Pearl Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAY 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 1922 to May 13, 1922, that I last saw h.e alive on May 13 1922, and that death occurred, on the date stated above, at 12½ P.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) operation

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 13

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Jay McKean, M. D.

, 19 (Address) The Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bedford Va

DATE OF BURIAL 5/13 1922

20 UNDERTAKER Chas. F. Evans & Son ADDRESS 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

64251 D 64251

HEALTH DEPARTMENT—CITY OF BALTIMORE

64251 D 64251

X 185

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH South Baltimore

City of BALTIMORE: (No. General Hospital. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos Stretch.

(Residence in Baltimore: No. Pimlico Race track. St.; yrs., mos. ds.) 21.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. October 1893. 1.....
(Month) (Day) (Year)

7-AGE 28 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Jockey.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). London Grove Pa.

PARENTS.

10-NAME OF FATHER. Richard Stretch.

11-BIRTHPLACE OF FATHER, (State or Country). Philadelphia Pa.

12-MAIDEN NAME OF MOTHER. Laura Miller.

13-BIRTHPLACE OF MOTHER, (State or Country). Dove Run Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Stretch.(father).

(Address) Lynny Pa.

15- Filed MAY 14 1922 19.. ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1922. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Laceration of the Brain, possible fracture of the skull. Accidental fall with horse while driving in steeblechase (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

May 13th 192 2 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Inj. at Pimlico Race track. May 12th, 1922.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Chester Pa. DATE OF BURIAL. 5 14. 19 22

20-UNDERTAKER. William Cook. ADDRESS 502 E Northam

N. B. In filling out this certificate, state CAUSE OF DEATH in plain terms. Indefinite or unscientific terms are not sufficient. See instructions on back of certificate. is very important.

Wilbur C. Manahan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64252 D 64252

D 64252

CERTIFICATE OF DEATH.

X 165 D 64252

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur Clayton Manahan

(Residence in Baltimore: No. 13- E. Center St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 23 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Clayton Manahan

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ida Bowen

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clayton Manahan

(Address) Highfield Md

Filed MAY 14 [redacted] 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Bichloride of Mercury

6 days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Culley (Coroner) M. D.

May 13, 1922 (Address) 1639 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 days yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, REMOVAL, ETC. Bethel Church Highfield

DATE OF BURIAL, May 14. 1922

20-UNDERTAKER Chas. G. Black

ADDRESS 742 W. North ave

N.B.—Every item of information should be given so that it may be properly classified. Especially CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64253

CERTIFICATE OF DEATH.

90 D 64253

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 W Lexington St., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M Mattingly

(a) RESIDENCE NO. 1316 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Female White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Mattingly

6 DATE OF BIRTH (month, day, and year) Nov. 9 1895

7 AGE Years 26 Months 6 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 531

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Chas Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Mercer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James R Mattingly

(Address) 1316 W Lexington St

15 MAY 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1922, to May 11, 1922, that I last saw her alive on May 11, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Post Systolic)

(duration) 3 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Oedema (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Moore, M. D.

, 19 (Address) 1119 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 15 1922

20 UNDERTAKER Harry F Weitzke

ADDRESS 153 Homelast St

mation should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64254

D 64254

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 911 N. Eden ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca V. Graydon

(a) RESIDENCE. NO. 911 N. Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of James W. Graydon

6 DATE OF BIRTH (month, day, and year) June 13 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Samuel Budge

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Elizabeth Hewett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant James W. Graydon

(Address) 911 N Eden St

15 MAY 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1922 to May 12, 1922

that I last saw h~~er~~ alive on May 12, 1922

and that death occurred, on the date stated above, at 8.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G. Owens, M. D.

May 13, 1922 (Address) 35 N Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL MAY 15 1922

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64255

CERTIFICATE OF DEATH.

90 D 64255

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 W. Ostend St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Kratz

(a) RESIDENCE. NO. 3 W. Ostend St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Margaret Kratz

6 DATE OF BIRTH (month, day, and year) Nov. 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Kratz

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

11 Informant Mrs M. M. Kratz

(Address) 3 W. Ostend St.

15 FILED MAY 14 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1922, to May 13 1922, that I last saw h— alive on May 12 1922, and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) yrs few mos. ds.

CONTRIBUTORY (Secondary) Rheumatism (duration unknown) mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. T. Seabury, M. D.

5/13, 1922 (Address) 638 Fork Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: 5/16 1922

20 UNDERTAKER: I. Few McCully

ADDRESS: 130 E. Fort

CAUSE OF DEATH in plain terms, so that it can be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64256

CERTIFICATE OF DEATH.

D 64256

REGISTERED NO. 45

1-PLACE OF DEATH St Agnes Hosp.

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Esther Cohen

(a) RESIDENCE NO. 1210 East Fayette St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Cohen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 35 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1409 E Balto St

15 Filed MAY 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25 1921 to May 12 1922

that I last saw h.. alive on 5-12-22 1922

and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5-26-21

Was there an autopsy? no

What test confirmed diagnosis? Operation - Clinical

(Signed) D. C. Caldwell M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Mt Carmel

DATE OF BURIAL 5/16 1922

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be [illegible]. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 D 64257

REGISTERED NO.

D 64257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3024 EVERGREEN TERRACE) WARD 13

2-FULL NAME Rosa GOLDMAN

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3024 Evergreen Terrace

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius Goldman

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: Years 47 Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Simon Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Esther Linick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Levi's 1439 Eastern Ave

15 MAY 14 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12 1922 to May 12 1922 that I last saw h alive on May 12 1922 and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Menopause (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — (duration) yrs. mos. ds.

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Gipe M. D.

5/13 1922 (Address) 6 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL 5/14 1922

20 UNDERTAKER: Jack Levi 1439 E Balto St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

D 64258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

4 D 64258

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 Little Carey St (Extended) 15 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Odelia Volandt

(Residence in Baltimore: No. 9 Little Carey St (Extended) St.; yrs. 48 mos. 4 ds. 15)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Dec. 25 (Month) (Day) 1873 (Year)

7-AGE. 48 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. William F. Volandt

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Volandt

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Volandt

(Address) 340 S Greenmount Ave

15-

Filed MAY 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. F. Hennessy M. D.

(Coroner.)

May 13 1922 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Pikesville DATE OF BURIAL. 5/15 1922

20-UNDERTAKER. William Cook ADDRESS 502 E North Ave

state CAUSE OF DEATH in plain English. It is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

15 3326
D 64259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-013
159 D 64259
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.: (WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Leinbach

(a) RESIDENCE. No. 2415 E North Ave ST., City WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of ~~or, WIFE of~~ Mrs. Schnke (Guardian)
1709 N Milton Ave

6 DATE OF BIRTH (month, day, and year) April 2, 1922

7 AGE: Years — Months 1 — Days 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Leinbach

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna C Gommard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAY 14 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to May 13, 1922, that I last saw her alive on May 13, 1922, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Microglossia (Congenital).

(duration) ..... yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Congenital.
Did an operation precede death? No Date of .....
Was there an autopsy? Yes.
What test confirmed diagnosis? .....

(Signed) Clara Thomson, M. D.
5/13 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 15 1922

20 UNDERTAKER: Henry Hoerle Sons — ADDRESS: 1301 E Eager St

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

75.00 D 64260

64260

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 E. 28th ST., 12 WARD)

2-FULL NAME Lydia M. Thomas

(a) RESIDENCE NO. 444 E. 28th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow-(Divorced)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher Fowler.

6 DATE OF BIRTH (month, day, and year) Sept. 25-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	85	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rhode Island.

PARENTS

10 NAME OF FATHER George W. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rhode Island.

12 MAIDEN NAME OF MOTHER Sarah A. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rhode Island.

14 Informant Sarah E. Hamilton (Address) 444 E. 28th St.

15 FILED MAY 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to May 13, 1922, that I last saw h... alive on May 12, 1922, and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) R. Hemiplegia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. Whitelo M.D.

(Address) 7800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elm Grove Cem. Rhode Island. DATE OF BURIAL May 16 1922

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. McCulloh St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 6426 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X 129 D 6426

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home Infy ST., 6 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Neff

(a) RESIDENCE No. Church Home Infirmary ST., WARD York-Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? 50 yrs. 7 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) about-1872

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	about 50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) York (Pa)

(State or country) Penna

PARENTS

10 NAME OF FATHER George Neff

11 BIRTHPLACE OF FATHER (city or town) York

(State or country) Pa

12 MAIDEN NAME OF MOTHER Miss Givens

13 BIRTHPLACE OF MOTHER (city or town) York

(State or country) Penna

14 Informant Mrs. E.M. Norris

(Address) York, Pa.

15 MAY 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922, to May 13, 1922,

that I last saw her alive on May 13, 1922,

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted (?), if not at place of death?

Did an operation precede death? yes Date of May 9, 1922

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) Coyston Fauntleroy M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York-Penna

DATE OF BURIAL May 14 1922

20 UNDERTAKER J. H. MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates.

See affidavit re Gaithier (Kavorkian

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 64262
REGISTERED No. C

D 64262

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 404 E. 20th St. Ward) Corrected number
2-FULL NAME Haig Kevorkian David Gaithier Haig Kavorkian
(Residence in Baltimore: No. 407 E. 20 St. St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, write its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M
4-COLOR OR RACE: W.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single
6-DATE OF BIRTH: ..... (Month) ....., 1 (Day) ..... (Year)
7-AGE: 35 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or.....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9-BIRTHPLACE, (State or Country): Baltimore
PARENTS.
10-NAME OF FATHER: Unknown
11-BIRTHPLACE OF FATHER (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (State or Country): Unknown
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rev Johnson
(Address) 14 De Eastern Ave
15- MAY 14 1922 ROBERT R. KRAUTER, Registrar.
Filed ....., 191.. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6 (Day), 1922 (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:
Gun Poison
Suicide
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John J. Kirwan M. D. (Coroner)
May 2, 1922 (Address) 703 E Balto St.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....
19-PLACE OF BURIAL, OR REMOVAL, Trinity Cemetery
DATE OF BURIAL, May 15, 1922
20-UNDERTAKER John A. Moran
ADDRESS 300 E Balto

N. B.—Every item of information must be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

& COPY.

Baltimore, Md., June 2, 1923.

I do hereby make oath that the name of deceased given on Baltimore City Department of Health Certificate of Death D-64262, date of death May 6, 1922, as David Gaithier is not correct, same should be recorded as Haig Kevorkian.

A. A. Thomas

Subscribed and sworn to before me this 2d day of June, 1923.

Reed Gaither
Notary Public.

Spec.—1-10-21—M&T—1500 Bks.

D 64263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64263

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH St. Agnes Hosp—

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 75 WARD)

2-FULL NAME Charles Ludwig

(a) RESIDENCE NO. Herkimer & Monroe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Amelia Ludwig

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Amelia Ludwig (Address) Monroe Park

15 MAY 14 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1922, to 5-13-, 1922,

that I last saw him alive on 5-13-, 1922,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum metastasis to glands of neck-

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cachexia - Cardiac failure - pulmonary oedema.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2-21-22

Was there an autopsy? No

What test confirmed diagnosis? Operative Clinical Observation

(Signed) ..... M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL May 16 1922

20 UNDERTAKER C. W. Dill — ADDRESS 319 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64264

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 Boyd ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franz Lüng

(a) RESIDENCE. No. 2101 Boyd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Lüng

6 DATE OF BIRTH (month, day, and year) Nov 29 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	14	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Tailor

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

080

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Lüng

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Maria Lüng

(Address) 2101 Boyd St

15 Filed MAY 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to May 12, 1922.

that I last saw him alive on May 12, 1922.

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Mitral Stenosis.)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E Helbig Hemming M. D.

5/12/1922 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL May 16 1922

20 UNDERTAKER C. W. Dill ADDRESS 310 Fredk. Ave.

Spec.—1-10-21—M&T—1500 Blks.

D 64265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64265

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 E. Fairmount ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H. Bozman

(a) RESIDENCE NO. 2043 E. Fairmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 27-92

7 AGE — Years: 30 — Months: 2 — Days: 15 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lineman

(b) General nature of industry, business, or establishment in which employed (or employer): C & P. Tel.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Somerset Co. Md.

PARENTS

10 NAME OF FATHER Albut Bozman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Sallie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Sallie Bozman

(Address) 2043 E Fairmount

15 FILED MAY 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July, 19 21, to May 11, 19 22.

that I last saw him alive on ....., 19 ....

and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Intuentis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Ralph L Stengt, M. D.

, 19 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: May 15 1922

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 64266

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

~~D-64266~~

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1838 N. Chester ST., 8 WARD)

2-FULL NAME Walter P. Grotjohann

(a) RESIDENCE NO. 1838 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? 26 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Roberta E. Grotjohann

6 DATE OF BIRTH (month, day, and year) Nov 8/82

7 AGE — Years: 39 — Months: 5 — Days: 5 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paint 066

(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10 NAME OF FATHER: Gustave Grotjohann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lidia Gyger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant (Address): Roberta Grotjohann 1838 N Chester St

15 Filed MAY 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1922, to May 11, 1922, that I last saw him alive on May 11, 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) Obs yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar C. Sandrock M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL: May 16 1922

20 UNDERTAKER: Philip Herrig ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64267

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 E. Biddle ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Wright

(a) RESIDENCE. No. 703 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1853

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Anne Wright (Address) 703 E Biddle St

15 Filed MAY 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to May 12, 1922, that I last saw him alive on May 12, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hanlon, M. D.

May 12 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Orang	5/15/22

20 UNDERTAKER: A G Wedefeld ADDRESS 914 Fremont Ave

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificate.

D 64268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64268

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1733 N Caste ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert L. Marshall,

(Residence in Baltimore: No. 1733 N Caste St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 22, (Day) 1893 (Year)

7-AGE. 26 yrs. 11 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. H. Marshall

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Lavinia A. Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Marshall

(Address) 1733 N. Caste

15- MAY 14 1922 ROBERT R. KRAUTER,
Filed..... 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 13 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) R. Krug Snyder M. D.
(Coroner.)

5-13-, 192.. (Address) 1 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, May 15, 1922

20-UNDERTAKER Fickler & Fickler

ADDRESS 1737 E. Eager

N. B.—Every item of information called for in CAUSE OF DEATH in plain terms, so that it may be properly classified, is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Podsinick ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64269

CERTIFICATE OF DEATH.

100-006 D 64269

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (NO. Ft. McHenry, Md. ST., 7 WARD)

2-FULL NAME Joseph Podsinick / Joseph F. Podsinick

(a) RESIDENCE NO. 2049 E. Monument St. Balto. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Podsinick Mrs. M. Podsminick

6 DATE OF BIRTH (month, day, and year) Nov 3, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant HOSP. RECORDS (Address) Ft. McHenry, Md.

15 Filed MAY 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922 to May 11 1922, that I last saw him alive on May 11, 1922, and that death occurred, on the date stated above, at 5:00 pm.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia -- (duration) -yrs. -mos. -ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? Yes data

What test confirmed diagnosis? Examination & Clinical

(Signed) A. D. Lust M. D.

Surgeon, U.S.P.H.S.

5/11 1922 (Address) U.S.V. Hosp. #56, Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL May 15 1922

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64270

CERTIFICATE OF DEATH.

179 D 64270

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Siewurski

(a) RESIDENCE NO. 620 S. Pond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknoen

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 14 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Siewurski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 MAY 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to May 11, 1922, that I last saw him alive on May 11, 1922, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde O'Donnell M. D.

5/13/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 16 1922
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank

CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64271

37 D 6427

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2314 Cambridge ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kojda

(a) RESIDENCE. NO. 2314 Cambridge ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none yet

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Kojda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Polek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Kojda
(Address) 2314 Cambridge

15 MAY 14 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-10-22, 19..., to 5-12-22, 19...

that I last saw h... alive on 5-12-22, 19...

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

(Address) 914 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanslaus — DATE OF BURIAL: 5/15/22

20 UNDERTAKER: John Mather — ADDRESS: 1803 Bank

mation should be carefully answered, so that it may be properly classified.
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64272

CERTIFICATE OF DEATH.

44 D 64272

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Blackowicz

(a) RESIDENCE. NO. 405 S. Medairy ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Blackowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Byedrek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Dombrowski (Address) 405 S Madeira St

15 Filed MAY 14 1922 ROBERT A. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6 1922 to May 13 1922 that I last saw her alive on May 13 1922 and that death occurred, on the date stated above, at 5 15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? Yes Date of 5/6/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W B Jones M. D.

5/13 1922 (Address) Lombard & Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 16 1922
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

64273 64273

HEALTH DEPARTMENT—CITY OF BALTIMORE

64273 64273

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) Homewood Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Garrett M. Cosgriff

(Residence in Baltimore: No. 3017 Barclay St.

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Dec. (Month), (Day), 1857 (Year)

7-AGE. 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Vermont

PARENTS.

10-NAME OF FATHER, John Cosgriff

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Cosgriff

(Address) 3017 Barclay St

15-

FILED MAY 15 1922 ROBERT R. KRAUTER, 191

Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) 11 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Contusion Entrance

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from: VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Burlington Vermont

DATE OF BURIAL, May 15 1922

20-UNDERTAKER Chas. T. Howe & Son

ADDRESS 1700 Eutaw Pl

CAUSE OF DEATH. ... important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 64274

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2715 W. North Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Ellen Young.

(a) RESIDENCE. No. 2715 W. North Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm J. G. Young Sr

6 DATE OF BIRTH (month, day, and year) Nov. 10-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Gloucester Va.

PARENTS

10 NAME OF FATHER Robert T. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gloucester Va.

12 MAIDEN NAME OF MOTHER Ellen F Dutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gloucester Va.

14 Informant Ada Young.
(Address) 2715 W. North Ave.

15 Filed MAY 15 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13- 1922

17 I HEREBY CERTIFY, That I attended deceased from 2-15, 1922, to 5-13-, 1922, that I last saw her alive on 5-12-, 1922, and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 28-21

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Chester Reland, M. D.

5-13 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 16th 1922
20 UNDERTAKER Jno Johannsen Sons	ADDRESS 946 Ausquith st

mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64275

D 64275

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Gough ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Sentoro

(Residence in Baltimore: No. 1307 Gough St.; .....yrs. .....mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Child

6-DATE OF BIRTH, July (Month) 5 (Day), 1921 (Year)

7-AGE, ...yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Antony Sentoro

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Emily De Pietro

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antony Sentora

(Address) 1307 Gough St.

15- Filed MAY 15 1922 191..... ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1922, to May 14 1922, that I saw h ex alive on May 14 1922, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

.....Measles.....

..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) .....yrs. .....mos. 1 ds.

(Signed) M. V. Kolb M. D.

5/14, 1922 (Address) 1515 N. Bentalou

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rood Cem. DATE OF BURIAL, May 16, 1922.

20-UNDERTAKER Jacob Frazier ADDRESS 28 S. Bond St.

Cross out what is not important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64276 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64276

CERTIFICATE OF DEATH. 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 117 Dolphin ST. (WARD)

2-FULL NAME Lilly L. Mc Cormick

(a) RESIDENCE NO. 117 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Charles H. McCormick

6 DATE OF BIRTH (month, day, and year) Nov 3. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	39	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jos. B. Calvert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary L. Beard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md.

14 Informant Charles H. McCormick (Address) 117 Dolphin St.

15 Filed MAY 15 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 22, 1922, to May 13, 1922, that I last saw h[illegible] alive on May 11, 1922, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

due to Hypertension.

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Walsh, M. D.

May 15th 1922 (Address) 2126 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL May 15 1922

20 UNDERTAKER John O'Mitchell — ADDRESS 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it can be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Wicks)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64277

38 D 64277

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Warren St. Mt. Winans (ST.) 25 (WARD)

2-FULL NAME. Mary Weeks

(a) RESIDENCE. NO. (end of) Warren St. Mt. Winans ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Weeks, Jr.

6 DATE OF BIRTH (month, day, and year) March 5, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER George Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Aaa Co Md

12 MAIDEN NAME OF MOTHER Ellen Galloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co Md

14 Informant (Address) Wm Weeks Mt. Winans, Md

15 Filed MAY 15 19 22 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13/1922

17 I HEREBY CERTIFY, That I attended deceased from 5/4/1922, to 5/12/1922, that I last saw h[illegible] alive on 5/10/1922, and that death occurred, on the date stated above, at 1 A. m

The CAUSE OF DEATH* was as follows:

Ruptured Aneurism

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. B. Hawkins, M. D.

(Address) 1216 S. H. Av. 5/13/1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 16 1922

20 UNDERTAKER Wm. H. Grace Co — ADDRESS 1400 W. Balto St

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks. CLARA M. MARCH

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64278 — 164 — D 64278

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 N. Gilmor ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara M. March.

(Residence in Baltimore: No. 920 N Gilmore St.; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. January 6, 1861. (Month) (Day) (Year)

7-AGE, 61 yrs. 4 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Washington March

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Martha McGinn

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William F. Wagner

(Address) 920 N. Gilmor St.

15-

FILED MAY 15 1922 191 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 11 1922, to May 12 1922, that I saw h[illegible] alive on May 10 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Dyspepsia

several hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile debility several years (Duration) yrs. mos. ds.

(Signed) G. Lafayette Dowell M. D.

May 13, 1922 (Address) 720 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	May 15, 1922
20-UNDERTAKER Henry W. Manning Sr.	ADDRESS 511 N. Schroeder St

Cases of [illegible] important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 64279

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Vine St ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Frankem

(a) RESIDENCE. No. 1825 Vine ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

3a If married, widowed, or divorced HUSBAND (or WIFE) of James Frankem

6 DATE OF BIRTH (month, day, and year) Unknown, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jas. Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Francis Bryan (Address) 1825 Vine St

15 MAY 15 1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 12, 1922, that I last saw h alive on May 11, 1922, and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

A, Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. M. Lee, M.D.

May 15 1922 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Lawn.	May 15 1922

20 UNDERTAKER David Wemsley ADDRESS 578 Eddie

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Spec.—1-10-21—M&T—1500 Bks.

D 64280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D 64280

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) Franklin Sq. Hospital ST., 14 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie V. Dickerson

(a) RESIDENCE NO. 1518 Mid Hill ad ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married
5a If married, widowed, or divorced HUSBAND of or) WIFE of: John H. Dickerson
6 DATE OF BIRTH (month, day, and year): Unknown 1868
7 AGE: Years 54 / Months / Days / If LESS than 1 day, ... hrs. or ..... min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): West River A. A. Co. Md
PARENTS
10 NAME OF FATHER: Henry Young
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Susan Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md
14 Informant: John L. Dickerson
(Address) 1518 Druid Hill Ave
15 Filed MAY 13 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/12 — 1922
17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to May -12-, 1922,
that I last saw her alive on May -12-, 1922
and that death occurred, on the date stated above, at 10.15 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Miliary Tuberculosis
of Intestines & Omentum
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 5/9/22
Was there an autopsy? no
What test confirmed diagnosis? Op. & Lab. findings
(Signed) Newton A Pass, M. D.
5/12, 1922 (Address) Franklin & Port

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem
DATE OF BURIAL: May 16 1922
20 UNDERTAKER: Samuel Beasley
ADDRESS 578 N Bdle

CAUSE OF DEATH in plain terms, so that it may be understood by all certificates. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 64281 — CERTIFICATE OF DEATH — D 64281

1001

1. PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 715 Bradley St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME William J. Riley

(Residence in Baltimore: No. 715 Bradley St.: 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6. DATE OF BIRTH: November (Month) (Day), 1870 (Year)

7. AGE: 52 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Public

9. BIRTHPLACE (State or country): Centreville Md

PARENTS

10. NAME OF FATHER: Robt Riley

11. BIRTHPLACE OF FATHER (State or country): Centreville Md

12. MAIDEN NAME OF MOTHER: Maria Coulbourn

13. BIRTHPLACE OF MOTHER (State or country): Centreville Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Annie Riley

(Address) 503 Bloom St

15. Filed MAY 15 1922 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1922 to May 13 1922

that I saw h[illegible] alive on May 11, 1922,

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. Hawkins M. D.

May 15, 1922 (Address) 1202 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Centreville Md — DATE OF BURIAL: MAY 15 1922

20. UNDERTAKER: Samuel T Hemsley — ADDRESS: 578 W Baltimore

Burial Permit Issued — REGISTRAR

N. B.—Every item of information should be given, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. It is very important. See instructions on back of certificate.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train — accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

154942
D 64282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001
100 D 64282
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elliott

(a) RESIDENCE. NO. 503 W. Hoffman St. 4th City WARD.
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~WIFE~~ of H. W. James (Friend) Fuston, Md.

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work.
(b) General nature of industry, business, or establishment in which employed (or employer) 503
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAY 15 1922 Registrar ROBERT R. KRAUTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1922, to May 12, 1922, that I last saw her alive on May 12, 1922, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Cystitis (duration) ..... yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) C. Sidney Burwell, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Virginia	May 15 1922
20 UNDERTAKER Samuel Kemsley	ADDRESS 1 E Baltimore

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64283

REGISTERED NO. 3 D 64283

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal tuberculosis Hospital (St.) 17 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeneva W. Stewart

(a) RESIDENCE. No. 1129 Brewer st. St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jennie Winer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records M.T.H.

15 Filed MAY 15 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to May 11, 1922, that I last saw her alive on May 11, 1922, and that death occurred, on the date stated above, at 9.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglicca M. D.

5-12-22 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 15th 1922

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1284 Etting St.

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D 64284

REGISTERED NO. .....

D 64284

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2910 E Monument ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Weber

(a) RESIDENCE NO. 2910 E Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Weber

6 DATE OF BIRTH (month, day, and year) July 28 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Himan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Esthubber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie M. Weber

(Address) 2910 E Monument

15 MAY 5 1922 ROBERT R. KRAUTER, Registrar

CAUSE OF DEATH: In plain words, give the exact cause of death in each case fully and specifically. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 13, 1922, that I last saw h alive on May 12, 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic arthritis (duration) 30 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Wheeler, M. D.

1922 (Address) 1211 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL May 15 1922

20 UNDERTAKER Geo E. Miller

ADDRESS 2334 Jeffrey

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64285

CERTIFICATE OF DEATH.

49

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 715 N. Duncan ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Bidlingmayer.

(a) RESIDENCE. NO. 715 N Duncan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Fanny Bidlingmayer.

6 DATE OF BIRTH (month, day, and year) Aug 30th - 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinest.

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Buttet Hayward

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John A. Bidlingmayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Frank Bidlingmayer 1708 E. Dunbarton St

15 MAY 15 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20 1922 to May 13 1922 that I last saw him alive on May 11 1922 and that death occurred, on the date stated above, at 1105 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma (Cerebral Thoracic Abdominal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical history —

(Signed) Louis A. W. Krause, M. D.

, 19 (Address) 2500 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 16 1922
20 UNDERTAKER	ADDRESS
Jno Wm T. Hartley	815 Washington

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 64286

CERTIFICATE OF DEATH.

31 D 64286

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 940 S. Bouldin ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Altvater

(a) RESIDENCE NO. 940 S. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Altvater

6 DATE OF BIRTH (month, day, and year) Oct. 4. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Elizabeth Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Elizabeth Birkefeld

(Address) 940 S. Bouldin Ste

15 MAY 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May, 1921, to May 11, 1922, that I last saw h[illegible] alive on May 11, 1922, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Lung)

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E. Krieghauser M.D.

May 13 1922 (Address) 2002 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL May 15 1922

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 E. Eager St.

CAUSE OF DEATH in your own words. See instructions on back of certificate. TION is very important.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64287

CERTIFICATE OF DEATH.

100 D 64287

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 N. Highland Ave ST., 16 WARD)

2-FULL NAME Edward G. P. Gieser

(a) RESIDENCE NO. 17 N. Highland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Dec. 7-1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	-	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George E. Gieser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Martha Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant George E. Gieser

(Address) 17 N. Highland Ave

15 MAY 15 1922 ROBERT R. KRAUTH Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 14, 1922, that I last saw him alive on May 14, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

ovw

Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. B Britton M. D.

May 4 1922 (Address) 1711 E Balto. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Cem. Stemmers Run — DATE OF BURIAL May 16 1922

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 E. Eager St.

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificate. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—1-10-21—M&T—1500 Bks.

Swan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64288

CERTIFICATE OF DEATH.

179 D 64288

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1600 E Lafayette Ave (ST.) 8 (WARD)

2-FULL NAME Elizabeth Swan.

(a) RESIDENCE NO. 1600 E Lafayette Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Swan

6 DATE OF BIRTH (month, day, and year) Feb 11 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None 000

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER James Waddell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elza Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant ..... (Address) 2301 Hillen St

15 Filed MAY 15 1922 ROBERT R. KRAUTER, Registrar

CAUSE OF DEATH to print legibly. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 1921 to May 13 1922,

that I last saw h[er] alive on May 12 1922,

and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Dropsy, myocarditis

(duration) about 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) about 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 16 1922

20 UNDERTAKER Wm. E. Tuckner — ADDRESS Balto

Spec.—1-10-21—M&T—1500 Bks.

D 64289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64289

CERTIFICATE OF DEATH.

REGISTERED NO. 1800

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2504 Frederick Ave St., 20 WARD)

2-FULL NAME Mrs Mary Helen Sipes

(a) RESIDENCE NO. 2504 Frederick Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Ephraim Owens Sipes

6 DATE OF BIRTH (month, day, and year) May 15 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER John R. Fraley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Maryland

12 MAIDEN NAME OF MOTHER Sarah E Mallonee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md.

14 Informant Mrs Gertrude Pitt
(Address) 2504 Frederick Ave.

15 MAY 15 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 13, 1922, that I last saw her alive on May 13, 1922, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Gilbert Reese, M. D.

5-13, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn cemetery — DATE OF BURIAL May 16 1922

20 UNDERTAKER W. J. Richardson — ADDRESS Walbrook

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64290

CERTIFICATE OF DEATH.

45 D 64290

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 404 Hollen Road, Cedarcroft St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel H. Pfeltz

(Residence in Baltimore: No. 404 Hollen Road, Cedarcroft, Govans St.: 68 yrs., 10 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 20 (Day), 1853 (Year)

7-AGE, 68 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retored
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George C. Pfeltz

11-BIRTHPLACE OF FATHER (State or Country), Do not know

12-MAIDEN NAME OF MOTHER Do not know

13-BIRTHPLACE OF MOTHER (State or Country), Do not know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert R. Pfeltz

(Address) 404 Hollen Road, Govans

15- Filed MAY 15 1922 191 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 9 1922, to May 14 1922, that I saw him alive on May 13 1922, and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Pelvic Cavity

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. M. Duncan M. D.

May 14th, 1922. (Address) 5104 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, 5/16, 1922

20-UNDERTAKER Henry W. Spears & Son

ADDRESS 505 N. Calvert St.

important. See instructions on back of certificate.

Ricker

64291

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 64291

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Presbyterian Eye & Ear Hospital ST. WARD)
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Kate Ricker

(Residence in Baltimore: No. 1218 S Paca St.; yrs., 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 23, (Day) 1844 (Year)

7-AGE, 77 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Cyrus Ricker

(Address) 1218 S. Paca

15- Filed MAY 15 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CAUSE OF DEATH to be plainly written. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 12, (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Accidental

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Kenton M. D. (Coroner.)

May 13, 1922 (Address) 1 Cedar St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet — DATE OF BURIAL, May 15, 1922

20-UNDERTAKER Geo. A. Farley — ADDRESS Fulton & Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 64292

HEALTH DEPARTMENT—CITY OF BALTIMORE

17-081 64292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Kenwood Ave ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lawrence

(a) RESIDENCE NO. 108 N. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick H. Lawrence

6 DATE OF BIRTH (month, day, and year) Oct 30, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Abendschein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Francis Fritch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amanda Lawrence (Address) 108 N. Kenwood Ave.

15 MAY 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th 1922 to May 13th 1922, that I last saw h W alive on May 12th 1922, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hammorhage

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert S. Kirk, M. D.

5/14 1922 (Address) 3126 Hayford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL May 16 1922

20 UNDERTAKER H. Sander & Sons — ADDRESS 1710 Fleet St.

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.–1-10-21–M&T–1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 64293

CERTIFICATE OF DEATH.

1922 HS 74-001 D 64293

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1361 N Stricker ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Herbert

(a) RESIDENCE NO. 1361 N Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 071

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER William H Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Susan Holbrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Katie Randall

(Address) 1361 N Stricker St

15 MAY 15 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CAUSE OF DEATH to be filled in by PHYSICIAN ONLY. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from May 11 –, 1922, to May 13, 1922, that I last saw her alive on May 13, 1922 and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. L. Kennard, M. D.

5-15 1922 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	May 16th 1922
20 UNDERTAKER	ADDRESS
Warren C Wright	1367 Mary

Spec.—6-9-19—H. P. Co.—1000 Bks.

155573

D 64294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64294

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Pulley City.

(a) RESIDENCE. No. 1531 Madison Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Della Pulley (wife).

6 DATE OF BIRTH (month, day, and year) June 30, 1860

7 AGE: Years 61 Months 11 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Bill Shew.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Annie Pulley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address) Record

15 Filed MAY 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to May 13, 1922, that I last saw him alive on May 13, 1922, and that death occurred, on the date stated above, at 12 3-5 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, hypertension, chr. nephritis, emphysema

(duration) several (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) short! yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Francis R. Dieuaide, M. D.

May 15, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int Auburn Cem

DATE OF BURIAL: 5/16th 22

20 UNDERTAKER: Jos. M. Skinner

ADDRESS: 1625 E. Monument

CAUSE OF DEATH. See instructions on back of this certificate. ATTENTION is very important.

Spec.—S 24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64295

CERTIFICATE OF DEATH.

REGISTERED NO. 179 D 64295

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S. Wolfe ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Flaherty

(Residence in Baltimore: No. 209 S. Wolfe St St.; 36 yrs., 5 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, November 22 (Month) (Day), 1885 (Year)

7-AGE,	If LESS than 1 day,
36 yrs. 5 mos. 22 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer): Dr

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Edward F. Flaherty

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Mary Banks

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Flaherty

(Address) 209 S. Wolfe St

15- Filed MAY 15 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 19 1922, to May 14 1922, that I saw h[illegible] alive on May 16 1922, and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Broadrup M. D.

May 14, 1922. (Address) 208 Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL. 5 17 ..., 1922

20-UNDERTAKER J. J. Moran

ADDRESS 3000 E. Balto.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15 5694
64296

HEALTH DEPARTMENT—CITY OF BALTIMORE) 64296

CERTIFICATE OF DEATH.

X 49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Newman

(a) RESIDENCE. NO. 32 S. Bond St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. How long in U. S., if of foreign birth? 2 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Esther Newman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Rabbi

(b) General nature of industry, business, or establishment in which employed (or employer) 865

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Cecil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed 5 15 1922, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 15, 1922, that I last saw him alive on May 15 - 1922 and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) 0 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis (duration) 0 yrs. 0 mos. 14 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 4/3/22

Was there an autopsy? No

What test confirmed diagnosis? Exploratory cystotomy

(Signed) Cecil H Bagley, M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	5/15 1922

20 UNDERTAKER Jack Lewis 1439 Eutaw ADDRESS

TION is very important. See instructions on back.

Y 15 1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Resident of Richmond, Va. Bed. 10 weeks at hospt.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lea Weisman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64297

D 64297

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. [redacted] ST.: 6 WARD)

2-FULL NAME Mrs. [redacted] Weisman

(a) RESIDENCE. NO. 1828 E. Baltimore ST., WARD.
(Usual place of abode) Baltimore, Md. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rev. Abraham Weisman

6 DATE OF BIRTH (month, day, and year) Aug. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. Baltimore St

15 Filed Robert P. Harrison, Registrar

MAY 15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922, to May 15, 1922, that I last saw her alive on May 14, 1922, and that death occurred, on the date stated above, at 1:10 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency with Org. Mitral disease & insufficiency

(duration) yrs. mos. 12+ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Rt. Partial expansion of Rt. lung

(duration) yrs. mos. 12+ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 7, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Price, M. D.

, 19 (Address) Union Memorial Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Northern Circle Interment Co. Rd	5/15 19 22

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

TION is very important. See instructions on back of

[illegible] STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operated on for suspected ulcer of stomach. None found. Nothing malignant.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64298

D 64298

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Patapsco ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank H. Callender

(a) RESIDENCE. NO. 1739 Patapsco ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 13-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry Callender

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind.

12 MAIDEN NAME OF MOTHER: Mary E. Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co. Md.

14 Informant: Mrs Charles E. Eckin

(Address) 1739 Patapsco St.

15 MAY 15 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to May 14, 1922, that I last saw h[illegible] alive on May 13, 1922, and that death occurred, on the date stated above, at 5.40A m.

The CAUSE OF DEATH* was as follows: Acute Cystitis duration

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis duration 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Forman Brune, M. D.

May 15, 1922 (Address) 1 E Read[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	May 17 1922

20 UNDERTAKER: George Schwab ADDRESS 701 Eutaw

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64299

D 64299

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1603 Ensor ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary. O'Brien

(a) RESIDENCE NO. 1603 Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas O'Brien

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
66				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER M. Harrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lillian Marcelette (Address) 1603 Ensor st

15 Filed May 15 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4th 1919 to May 13th 1922, that I last saw h[illegible] alive on May 12th 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no + microscopic

What test confirmed diagnosis? Phys. Signs, Symptoms

(Signed) Dr. M. C. Clarke, M. D.

May 13th 1922 (Address) 1114 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL 5/16 1922

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64300

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: ~~NO.~~ City Hospital (Bay View) ST., 24th WARD)

2-FULL NAME. Andrew Wallace

(a) RESIDENCE NO. 1221 Riverside Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? (1842(?))

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Ship caulker

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henson Wallace

11 BIRTHPLACE OF FATHER (city or town) Unknown. (State or country)

12 MAIDEN NAME OF MOTHER Susan Brady.

13 BIRTHPLACE OF MOTHER (city or town) Prince George (State or country) county. Md.

14 Informant City Hospital Records (Address)

15 MAY 15 1922 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1922

17

I HEREBY CERTIFY, That I attended deceased from May 6th, 1922, to May 14th, 1922, that I last saw him alive on May 13th, 1922, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Acute retention of urine (from benign Prostatic enlargement.)

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? signs & symptoms

(Signed) E. Martinez, M. D.

, 19 (Address) City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL 5-16 1922

20 UNDERTAKER E. T. Hale ADDRESS 115 E. West St.

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64301

CERTIFICATE OF DEATH.

D 64301

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2626 Bernard ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L Townsend

(a) RESIDENCE. No. 2626 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Aug 6 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cora Jeffery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cora Townsend

(Address) ~~2626 Bernard St~~

15 Filed . 19 Registrar

MAY 15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from March . 1922, to May 13 . 1922, that I last saw h— alive on May 13 . 1922, and that death occurred, on the date stated above, at 1025 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Independent (duration) 3 yrs. + mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) E B Nowell M. D

3/4 . 1922 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL May 16 1922

20 UNDERTAKER Chenowith Son — ADDRESS Chestnut Ave

CAUSE OF DEATH. See instructions on back TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64302

HEALTH DEPARTMENT—CITY OF BALTIMORE

118 D 64302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pleck

(a) RESIDENCE. No. 603 N. Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Pleck

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 53 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Thomas Pleck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Emma Pleck
(Address): 1036 E. Eden

15 Filed 5 15 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-13 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-12, 1922 to 5-13, 1922, that I last saw him alive on 5-13, 1922 and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema 12 hrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-12-22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Ernest Edelmann, M. D.

5-13, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 16 1922

20 UNDERTAKER: Frank Enochs — ADDRESS: 1906 Eastern Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64303

CERTIFICATE OF DEATH.

D 64303

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 N Madison St.; WARD)

2-FULL NAME James Paduck

(a) RESIDENCE. NO. 902 N. Madison St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 17 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Louis Paduch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Josefa Kolar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Louis Paduch
(Address) 902 N Madison St

15 ... 19 ... Registrar

Robert P. Harrison,
Burial Permit Clerk

15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch. 12, 1922, to May 14, 1922, that I last saw h— alive on May 14, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilmer D Rysom, M. D.

May 15 1922 (Address) 801 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: May 17 1922

20 UNDERTAKER: Frank Crack & Sons

ADDRESS: 1900 Eastern Ave

CAUSE OF DEATH. See instructions on back of this sheet. ATION is very important.

D 64304

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 64304

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. U. S. D. ST. 28 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Renner
(Residence in Baltimore: No. Zimmerman Ave, W. Arlington St.: yrs. 61 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Sept. 12, 1860
(Month) (Day) (Year)

7-AGE, 61 yrs. 8 mos. 2 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Weigher (Grains)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto. Md,

PARENTS.
10-NAME OF FATHER, Frank Renner
11-BIRTHPLACE OF FATHER (State or Country), Md.
12-MAIDEN NAME OF MOTHER Davis Kenn
13-BIRTHPLACE OF MOTHER (State or Country), Davis Kenn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Margaret Renner
(Address) 2204 Guilford Av.

15- Robert P. Harrison,
....., 191.... Registrar.

15 1922 Burial Permit Clerk.

CAUSE OF DEATH in plain terms. Be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1922,
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to.. his death on the day stated above.
The CAUSE OF DEATH* was as follows:
(Suicide by gunshot wound in head
(Duration) ....yrs. ....mos. 3 ...ds.
CONTRIBUTORY (Secondary) Temporary insanity
(Duration) ....yrs. ....mos. ....ds.
(Signed) J. T. Hennessy M. D.
(Coroner.)
May 15, 1922 (Address) 28 Washington Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos. 3 ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Zimmerman Ave, W. Arlington St.
Former or usual residence Davis

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Cemetery, Md. DATE OF BURIAL, May 16, 1922

20-UNDERTAKER Henry Heck & Son ADDRESS 1201 Fagot

Spec.—8-24-14—M. & T.—2000 Bks.

D 64305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64305

CERTIFICATE OF DEATH.

REGISTERED NO. C 64305

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Hilton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catharine Allen

(Residence in Baltimore: No. 1513 Hilton St.; 88 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. (Month) 29, (Day) 1833 (Year)

7-AGE, 88 yrs. 8 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work —— (b) General nature of industry, business, or establishment in which employed (or employer) —— 800

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. William Allen

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Jane Harper

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Robt Lawrence

(Address) 1402 Park Ave

15-

Filed....., 191..... Registrar.

Robert P. Harrison,

1 5 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 13 1922, to May 14 1922, that I saw h[illegible] alive on May 14 1922, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Infirmity of Age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia (right) Thrombosis about 12 days

(Duration) yrs. mos. ds.

(Signed) Dalton McCook M. D.

May 15, 1922 (Address) 1107 W. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount-Cem. DATE OF BURIAL, May 16, 1922

20-UNDERTAKER Chas. E. Franck ADDRESS 842 Madison

important. See instructions on back of Certificate

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64306

D 64306

38

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Male Baby Marseghe

(a) RESIDENCE NO. 635 W. Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10 1922

7 AGE: Years | Months | Days | If LESS than 1 day, 1 hrs. or 10 min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ppo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mercy Hospital Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Marseghe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Jennie Lumiello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mercy Hospital Record (Address)

15 MAY 15 1922, 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 10, 1922 that I last saw him alive on May 10, 1922 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows: Congenital Syphilis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Atelectasis (duration) 1 hr 15 min yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 10, 1922

Was there an autopsy? yes

What test confirmed diagnosis? Findings Physical Sign

(Signed) John J. Erwin, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

Per. Wm. E. Woodall

MAY 1 1922

CAUSE OF DEATH must be written in full. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 64307

D 64307

31

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeths Home ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Smith

(a) RESIDENCE. NO. St. Elizabeths' Home Chestnut Hill Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: negro

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1/21

7 AGE — Years: — Months: 11 — Days: 13 days. — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 [illegible] 1922 . 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1922

17 I HEREBY CERTIFY, That I attended deceased from February, 1922, to May 12, 1922, that I last saw him alive on May 12, 1922, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Glandular Tuberculosis (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank J. Boyd, M. D.

, 19 (Address) 2008 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 1922

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 64308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64308

CERTIFICATE OF DEATH.

91 00 2/6

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

2-FULL NAME Mary Ann Luse

1a) RESIDENCE NO. 2133 E. Federal St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER David Cromer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rochina Ryhr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Hospital Records,

(Address) Municipal Hospital

15 5/15 1922, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain words. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 19 22

17

I HEREBY CERTIFY, That I attended deceased from May 6, 19 22. to May 14, 19 22.

that I last saw her alive on May 14, 19 22.

and that death occurred, on the date stated above, at 12:05 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 30 yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Bronchitis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde M. Snell, M. D.

5/15/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Coburn Pa.

DATE OF BURIAL May 15 19 22

20 UNDERTAKER Robt. E. Sumner

ADDRESS 1 N Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64309

CERTIFICATE OF DEATH.

D 64309

114

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Edmondson av ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martina A Newton

(a) RESIDENCE. NO. 1817 Edmondson av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry G Newton

6 DATE OF BIRTH (month, day, and year) Unknown 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 137

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Capt Charles Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Mary Ann Vary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Henry G. Newton (Address) 1817 Edmondson av

15 May 15 1922 . 19 Registrar

Albert F. HARRISON, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 13, 1922, that I last saw h[illegible] alive on May 13, 1922, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Auto intoxication

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) E. M. Lamperson, M. D.

May 13 1922 (Address) 826 N. Carrollton av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 16 1922

20 UNDERTAKER: George J Smith — ADDRESS 100 N. Fayette st

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64310

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3814 Monastery Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida A. Todd

(a) RESIDENCE. No. 3814 Monastery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, ~~or divorced~~ ~~(HUSBAND)~~ of (or) WIFE of: Wm M. Todd

6 DATE OF BIRTH (month, day, and year): Oct 27, 1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: Thos. H. Emrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chestertown Md

12 MAIDEN NAME OF MOTHER: Margaret Kinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Nellie E. Meredith
(Address) 2121 W. North ave

15 Filed ..., 19... Registrar

MAY 15 1922 Burial Permit Clerk.

CAUSE OF DEATH TO BE PLAINLY WRITTEN. PENCIL NOT ACCEPTABLE. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1922

17

I HEREBY CERTIFY, That I attended deceased from April 31, 1922, to May 14, 1922, that I last saw h[illegible] alive on May 14, 1922, and that death occurred, on the date stated above, at 8 04 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

Endocarditis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Gatch, M. D.

5/15, 1922 (Address) 2151 Walkers ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: May 16 1922

20 UNDERTAKER: Harry W. Ehlen

ADDRESS 1944 W. North ave

Spec.—1-10-21—M&T—1500 Bks.

D 64311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 64311

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 E Gittings ST., 24 WARD)

2-FULL NAME Mary Murphy.

(a) RESIDENCE NO. 1132 E Gittings ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Nicholas Murphy

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER M. O'Grady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Do- nat Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Nicholas Murphy
(Address) 1132 E Gittings St

15 Robert F. Harrison, Registrar
May 15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1922, to Mar 14, 1922, that I last saw h alive on Mar 14, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinate (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Ephendian (duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinically

Signed) R. F. Campbell, M. D.
May 16, 1922 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	5/16/ 1922
20 UNDERTAKER	ADDRESS
John J. Fahey & Sons	1318 Eutaw

CAUSE OF DEATH in plain words. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 64312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64312

CERTIFICATE OF DEATH.

100-

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Anna Evers

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1826

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	? 95 or 86 ?	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed Robert P. Harrison, Registrar

15 1922 Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17

I HEREBY CERTIFY, That I attended deceased from May 6 1922 to May 14 1922,

that I last saw her alive on May 14 1922,

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

5/15 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 16 1922
20 UNDERTAKER	ADDRESS
Mrs C. Butler	2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64313

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 44 D 64313

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 15 17 Division St.: 14 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Crowell Cunningham

(a) RESIDENCE. No. Cumberland, W. Va St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White American	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sarah E Cunningham

6 DATE OF BIRTH (month, day, and year) Jan 8 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER John S.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Selena Crowell

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Sarah E Cunningham (Address) 13 Linden Ave Clarksburg W Va

15 Filed Robert P. Harrison Registrar

MAY 16 1922 Burial Permit Clerk.

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to May 15, 1922, that I last saw h[illegible] alive on May 15, 1922, and that death occurred, on the date stated above, at 9.45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral embolus. 8 V G N

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 15, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. S. Snee, M. D.

, 19 (Address) Union Memorial Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksburg West Va	May 16 1922
20 UNDERTAKER	ADDRESS
William Lee	1502 E North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operated on first for carcinoma Goldbach
Second operation for intestinal adhesions.

D 64314 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64314

CERTIFICATE OF DEATH. 148 Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 421 E 23rd St., 12 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachela Cozzelli
(Residence in Baltimore: No. 421 E 23rd St. (If non-resident give usual residence.) (Hrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE. White
5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married
6-DATE OF BIRTH. July (Month) 13 (Day) 1895 (Year)
7-AGE. 26 yrs. 10 mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General natnre of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Italy

PARENTS.
10-NAME OF FATHER. Carmine Zerrandi
11-BIRTHPLACE OF FATHER, (State or Country). Italy
12-MAIDEN NAME OF MOTHER. Salome Zerrandi
13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Enrico Cozzelli
(Address) 421 E. 23rd St.

15- Filed May 15 1922 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 15 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.
The CAUSE OF DEATH* was as follows: Childbirth

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) (Coroner.) M. D.
1922 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death*?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. May 17 1922
20-UNDERTAKER. ADDRESS
William Cook 502 E Nath Ave

is very important. See instructions on back.

Mousey 3632 Roland Ave.

Spec.—1-10-21—M&T—1500 Bks.

(Dauphin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64315

CERTIFICATE OF DEATH.

D 64315

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 E. Balto St. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christinna Dauphin.

(a) RESIDENCE NO. 1435 E. Balto St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ. 75 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow (Widow)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known.

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 83 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): At Home—

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Not Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Leon W. Dauphin 1435 E. Balto

15 Filed 19 Robert P. Harrison, Registrar

15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1922, to May 14th, 1922, that I last saw h[er] alive on May 12th, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination clinically.

(Signed) A. F. Reis, M. D.

May 14, 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk. —

DATE OF BURIAL: May 16 1922

20 UNDERTAKER: Wm Cook — 502 E. North Ave.

ADDRESS

CAUSE OF DEATH. See instructions on back of this sheet. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64316
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

164D 64316
REGISTERED NO. C

CITY OF BALTIMORE: (No. 6235 Blenheim Road. ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Dorothea Caroline Schwarz

(Residence in Baltimore: No. 6235-Blenheim Road St.; 68 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, October 13, 1826.
(Month) (Day) (Year)

7-AGE, 95 yrs. 7 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Hanover, Germany.

PARENTS.

10-NAME OF FATHER, Conrad Franke

11-BIRTHPLACE OF FATHER (State or Country), Hanover, Germany.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Probably Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bertha D. Heldman (daughter)

(Address) 6235 Blenheim Road, City.

15-

Filed ..... 191.. Robert P. Harrison, Registrar.

Y 15 1927

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1927, to May 14 1927, that I saw her alive on May 14 1927, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

General Giving out of Vital Forces- With No disease whatever

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. M. Duncan M. D.

May 14, 1927 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
LOUDON PARK CEMETERY	May 16 1927

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64317

CERTIFICATE OF DEATH.

D 64317

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Hanford Pond

(a) RESIDENCE. No. Franklin Av. (Raspeburg) ST., 26 WARD. Pottstown Pa. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. 11 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Strong Pond

6 DATE OF BIRTH (month, day, and year) May-15-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) New York City, N.Y.

PARENTS

10 NAME OF FATHER Albert Hanford

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York, N.Y.

12 MAIDEN NAME OF MOTHER Mary Chester.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanta Georgia.

14 Informant (Address) Mr. Theo. H. Pond, (son) Franklin Av., Raspeburg, City.

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk

151[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10 1922, 19..., to May 14 1922, 19...

that I last saw h[illegible] alive on May 14 1922, 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Pleurisy

(duration) — yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis (duration) ..... yrs. mos. 6 hrs.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clin. findings

(Signed) J. A. Lowenkron, M. D.

, 19 (Address) Mt. Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pottstown, Penna. DATE OF BURIAL May-16-1922

20 UNDERTAKER STUART A. MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 103 W. NORTH AVE.

Val 5

TION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64318

D 64318

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 N Franklin ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John O Keefer

(Residence in Baltimore: No. 1204 Franklin St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	S

6-DATE OF BIRTH. August (Month) 22 (Day), 1851 (Year)

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer). Hats

9-BIRTHPLACE, (State or Country). Frederick City Md

PARENTS

10-NAME OF FATHER. Dennis P. Keefer

11-BIRTHPLACE OF FATHER (State or Country). Frederick Co Md

12-MAIDEN NAME OF MOTHER Lucie Dorsh

13-BIRTHPLACE OF MOTHER (State or Country). Frederick Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Keefer

(Address) 1204 Franklin St

15-

Filed Robert J. Harrison, Registrar.

MAY 15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 13 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 8 1922, to May 13 1922, that I saw h alive on May 10 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

2 weeks (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy (Duration) 2 mos. ds.

(Signed) John A Cain M. D.

May 16 1922 (Address) 10 N Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	5-16, 1922
20-UNDERTAKER	ADDRESS Fulton
Robt Brooks & Son	Hollins st

Important. See instructions on

Patient has headed this patient for years. The last illness however was of a few days duration. Patient has been confined to house for two years. Dr. F. H. Hennessy

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc; Carcinoma, Sarcoma, Cancer, Tumor, Cerebral hemorrhage, Uremic coma*, etc., of..... (name organ, if any). Cancer, etc., less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 64319

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3832 Reisterstown Rd. WARD 15)

2-FULL NAME Mrs Mary Lucretia Porter

(a) RESIDENCE. NO. 3832 Reisterstown Rd WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob E. Porter.

6 DATE OF BIRTH (month, day, and year) May 24, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER William Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.

12 MAIDEN NAME OF MOTHER Catherine C. Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Wm. H. Moore (Address) 3832 Reisterstown Road

15 MAY 5 1922 19 Robert P. Harrison, Registrar

Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from 25 April, 1922, to 14 May, 1922, that I last saw h er alive on 14 May, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Horace W Bryant, M. D.

(Address) 749 W. 168th Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: May 16 1922

20 UNDERTAKER: William Lotz — ADDRESS

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

Harrison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64320

D 64320

CERTIFICATE OF DEATH.

74-101

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 814 Homeworn ST., 13 WARD)

2-FULL NAME Daisy Hairston

(a) RESIDENCE NO. 814 Homeworn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Out door

(c) Name of employer unknown

9 BIRTHPLACE (city or town) ...
(State or country) Va.

PARENTS

10 NAME OF FATHER Thos. Wilson

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Va.

14 Informant Mary Alexander
(Address) 814 Homeworn St.

15 MAY 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13 1922

17 I HEREBY CERTIFY, That I attended deceased from 1920, 19 ..., to 5/13, 1922.
that I last saw her alive on 5/10, 1922
and that death occurred, on the date stated above, at 8:15 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage —
Apoplexy —

(duration) yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Influenza & Organic

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Ellis, M. D.

(Address) 92 Laurens

5/16, 19 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL 5/17th 1922

20 UNDERTAKER Jas. M. Skinner ADDRESS 620 E. Broadway

CAUSE OF DEATH must be given. See instructions on back of certificate. TION is very important.

D 6432 P

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6432 P

CERTIFICATE OF DEATH.

165

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersey Hospital ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harvey Berralt

(Residence in Baltimore: No. 556 W Conway St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colrd	Sgle

6-DATE OF BIRTH, ... Dec 8 ....., 1 ..... (Month) (Day) (Year)

7-AGE, 41 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... mln.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John Berralt

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Nelie Plunder

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hattie Wood M Brown

(Address) 1018 W Monty St

15- MAY 16 1922

Filed ..... 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CAUSE OF DEATH is public and important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May ..... 14 ....., 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (Inquest, ~~au-~~ ~~topsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Todies Poisoning

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Jaundice

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W S Gonnella M. D. (Coroner.)

5-15-, 192 (Address) N 7 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Int Calvert Ct	May 16, 1922
20-UNDERTAKER	ADDRESS
I. H. Brown and Son	1018 W. Monty St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64322

CERTIFICATE OF DEATH.

X31 D 64322

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) 17 (Ward)

2-FULL NAME Jasper Langon

(a) RESIDENCE. No. 568 W. Preston st. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~Unknown~~ 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Willie Langon

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer O&D

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country) Iowa Virginia

PARENTS

10 NAME OF FATHER Hugh Langon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records M.C.H.

15 MAY 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1922. to May 13, 1922.

that I last saw him alive on May 13, 1922.

and that death occurred, on the date stated above, at 5:05 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L. Dadaylucca, M. D.

5-13-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Iowa Va — DATE OF BURIAL: MAY 16 1922

20 UNDERTAKER: Saml. B. Townley — ADDRESS 578 W Biddle

CAUSE OF DEATH. This information is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 64323

REGISTERED NO.

64323

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 301 S. Chester ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Hubble

(a) RESIDENCE NO. 301 S. Chester ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Hubble

6 DATE OF BIRTH (month, day, and year) Oct. 28 1833.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	88	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Hart.

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Harriett Lambdin

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Hannah Jordan

(Address) 301 S Chester St.

15 MAY 16 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1922, to May 14th, 1922

that I last saw h[illegible] alive on May 14th, 1922

and that death occurred, on the date stated above, at 10 50 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 14 1922 (Address) #2 n Bentley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL May 16 1922

20 UNDERTAKER Lilly + Zeller ADDRESS 403 S. Wolfe

CAUSE OF DEATH to print legibly. See instructions on back of Certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64324

CERTIFICATE OF DEATH. 31

D 64324

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Echodale Ave St.; Hamilton WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Lillie Virginia Finch

(Residence in Baltimore: No. 12 Echodale Ave St.; Lifeline yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) 22 (Day), 1864 (Year)

7-AGE, 58 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, John Finch

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Cummings

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E H Kerncke

(Address) 12 Echodale Av

15-

Filed MAY 16 1922 ROBERT N. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 2 1922, to May 14 1922, that I saw h[er] alive on May 13 1922, and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis.

(Duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) 5 yrs. 6 mos. — ds.

(Signed) George E. Shannon M. D.

May 14, 1922 (Address) 701 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, May 17, 1922

20-UNDERTAKER George J Smith

ADDRESS 100 N Fayette

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64325 D 64325

CERTIFICATE OF DEATH.

5129 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 E Fayette ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Liba Kadansky

(Residence in Baltimore: No. 1426 E Fayette St.; 24 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE, 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss N. Kadansky

(Address) 1426 E. Fayette St

15-MAY 16 1922 ROBERT R. KRAUTER, Filed ....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 16, (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922, to May 15 1922, that I saw her alive on May 15 1922, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) hypostatic pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benj. Kadan M. D.

....., 191... (Address) 230 E. Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sinai-Rockem Ave. DATE OF BURIAL, 5-16-, 1922

20-UNDERTAKER East Lewis ADDRESS 1434 E Baltimore

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64326

CERTIFICATE OF DEATH.

182 D 64326

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of President st - 3 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Andrew Kalek

(Residence in Baltimore: No. 1515 Fleet st - St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. 16, 1916
(Month) (Day) (Year)

7-AGE, 5 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Antoni Kalek.

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Catharine Gablis

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antoni Kalek

(Address) 1515 Fleet St

15-

Filed MAY 16 1922 ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Fell overboard

(Duration) .....yrs.....mos.....ds.

(Signed) Thos B Norton M. D.
(Coroner)

May 15 1922 (Address) Curtis Bay Balto Md.

*State the DISEASE CAUSING DEATH, or, in deaths FROM VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, May 17 1922

20-UNDERTAKER William Jackson — ADDRESS 1617 East

CAUSE OF DEATH in plain terms, and must be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 64327 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D 64327

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33 3rd Ave Wagners Pt. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Iwanczuk

(a) RESIDENCE NO. 33 3rd Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 22-1919

7 AGE: Years 2 Months 3 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Antoni Iwanczuk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Weronika Kapturs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant (Address): Weronika Iwanczuk Wagners Pt

15 Filed MAY 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to May 14, 1922, that I last saw h— alive on May 14, 1922, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

OVER

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Stopka, M. D.

5/16, 1922 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Holy Cross Cem DATE OF BURIAL 5/16 1922

UNDERTAKER: W. H. Falkenhan ADDRESS

CAUSE OF DEATH must be given. See instructions on back of Certificate. TION is very important.

(See affadivit over)

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 64328

CERTIFICATE OF DEATH

Registered No. C 44

) 64328 PLACE OF DEATH

CITY OF BALTIMORE (No. 411 N. Stricker St. 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura E. Medwell

(Residence in Baltimore: No. 411 N. Stricker St. 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: July (Month) 17, 1848 ~~1850~~ (Day) (Year)

7-AGE: 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Dorchester Co

PARENTS

10-NAME OF FATHER: Luther M Hall

11-BIRTHPLACE OF FATHER (State or country): Dorchester Co

12-MAIDEN NAME OF MOTHER: Rachel Lean

13-BIRTHPLACE OF MOTHER (State or country): Dorchester Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura Medwell

(Address) 411 N. Stricker

15. MAY 1 0 1922 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 13 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1922 to May 13 1922 that I saw her alive on May 13, 1922 and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows: Midnight

Stricture of Oesophagus
(Possibly Carcinoma) abt 6
(Duration) yrs. mos. ds

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
May 14, 1922 (Address) W B Rider

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: 5-16, 1922

20-UNDERTAKER: W. E. Brown & Son

ADDRESS: 5 W. N. Broadway

N. B. Every CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is very important. See instructions on back of certificate.

Baltimore, Md., May 17, 1922.

I do hereby make oath that the age of deceased, Laura E. Nedwell, given on Baltimore City Health Department Certificate of Death - D 64328, as 61 years is not correct. The date of birth should be recorded as 1848 instead of 1860 and the age 74 yearsinstead of 61 years, as recorded on said certificate.

Annie E Nedwell
Daughter.

Subscribed and sworn to before me this 17th day of May, 1922.

Paul Gunther
Notary Public.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64329

CERTIFICATE OF DEATH.

H D 64329

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Bedell Garrett Jeans

(Residence in Baltimore: No. 1321 Madison Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 ..... (Year)

7-AGE, 50 ? yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Liquor Dlr
(b) General nature of industry, business, or establishment in which employed (or employer) Broker

9-BIRTHPLACE, (State or Country). Georgia

PARENTS.

10-NAME OF FATHER, dont Know

11-BIRTHPLACE OF FATHER (State or Country). dont Know

12-MAIDEN NAME OF MOTHER dont Know

13-BIRTHPLACE OF MOTHER (State or Country). dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. J. A. Rogers

(Address) 210 Guilford Ave

15- GG

Filed MAY 16 1922 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1922, to May 14 1922, that I saw h[illegible] alive on May 14 1922, and that death occurred, on the date stated above, at 1205 P m.

The CAUSE OF DEATH* was as follows: COR

Myocardial Insufficiency

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Sepsis

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Herman J. Dorf M. D.

5/17, 1922. (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Midland-Geo Lin

DATE OF BURIAL, 5-16, 1922

20-UNDERTAKER Henry A Jackson (Lovola)

ADDRESS McCulloh & Richard

Important. See instructions on back.

D 64330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64330

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Davison Chemical Company,

City of BALTIMORE: (No. Curtis Bay. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Thompson. 13 ----------

(Residence in Baltimore: No. 128 W. Conway St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced, (Write the word.): Single.

6-DATE OF BIRTH: July, 11th. 1857. (Month) (Day) 1..... (Year)

7-AGE: 64 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): O/S

9-BIRTHPLACE, (State or Country): Danville, Canada.

PARENTS.

10-NAME OF FATHER, Willian Thompson.

11-BIRTHPLACE OF FATHER, (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Catherine Thomson.

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Thompson. (sister)
557 Locust Ave.
(Address) Germantown, Pa.

15- Filed MAY 16 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12th. 1922. (Month) (Day) 192..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valuular disease of the Heart.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Otto T. Reinhardt M. D. (Coroner.)

May. 15th 1922. (Address) 1217 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet — DATE OF BURIAL, May 16 1922

20-UNDERTAKER, John F. Denny — ADDRESS 715 Light St

is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Bks.

D 64331

64331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 Stockton ST., 15 WARD)

2-FULL NAME John Wesley Boyer

(a) RESIDENCE NO. 1326 Stockton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Amanda Boyer ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Business

(c) Name of employer George Schumacher

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Eliza Brooks

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Md.

14 Informant Amanda Boyer (Address) 1326 Stockton St

15 Filed MAY 16 1922 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 1922, to May 13, 1922, that I last saw him alive on May 13, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. William Frey M. D.

5/14 1922 (Address) 1928 Bruns Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem | DATE OF BURIAL May 16 1922

20 UNDERTAKER James F. Mann | ADDRESS 203 Fremont

CAUSE OF DEATH. See instructions on back of Certificate. ATTENTION is very important.

Spec.—5-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64332

CERTIFICATE OF DEATH.

D 64332

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3312 W. North ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wilson Trofell

(a) RESIDENCE. No. 3312 W. North ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Reese Trofell

6 DATE OF BIRTH (month, day, and year) Sept 11. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Frederick W. Trofell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Rave

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary K. Trofell
(Address) 3312 W. North Ave

15 Filed MAY 16 1922 Registrar ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922, to May 14, 1922, that I last saw h[illegible] alive on May 14, 1922, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - Angina pectoris

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted ✓
If not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Fuel Leitz, M. D.

5/15, 1922 (Address) 7040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: May 16 1922

20 UNDERTAKER: John O. Mitchell ADDRESS 1201 W. Fayette

TION is very important. See instructions on back

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. D 64333

CITY OF BALTIMORE: (No. 4100 Groveland Ave ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth R Lerch

(Residence in Baltimore: No. 4100 Groveland Ave St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Jan 10, 1853 (Month) (Day) (Year)

7-AGE, 69 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Centreville Md

PARENTS.

10-NAME OF FATHER, Samuel E. Dyott

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Henrietta R Dyott

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry E Dyott

(Address) 4100 Groveland Ave

15- Filed MAY 16 1922 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1922, to May 14 1922, that I saw h[illegible] alive on May 14 1922, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. G. Tyson, M. D.

5/16, 1922 (Address) 3501 Lawrence Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, May 16, 1922

20-UNDERTAKER John O Mitchell

ADDRESS 1201 W Fayette

important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 64334

CERTIFICATE OF DEATH.

REGISTERED No. C

D 64334

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 W. 27th st. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederica Nabakowski

(Residence in Baltimore: No. 329 W. 27th st. St.; 37 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, May 6th 1863, 1 (Month) (Day) (Year)

7-AGE, 59 yrs. mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, A. Brenner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Brasel

(Address) 329 W. 27th St.

15-

Filed MAY 18 1922

Registrar.

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 10 1922 to May 12 1922 that I saw h[illegible] alive on May 13 1922, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Delirium

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. 3 mos. ds.

(Signed) Lue Fellows M. D.

5/16, 1922 (Address) 2724 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, May 16, 1922

20-UNDERTAKER Harry H. Witzke ADDRESS 1531 N. Fountain

Spec.—6-9-19—H. P. Co.—1000 Bks.

64336

(Schumacher) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9/D 64335

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 419 S Washington ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabette Schomacher

(a) RESIDENCE. NO. 419 S. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of John Schomacher

6 DATE OF BIRTH (month, day, and year) [illegible] 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Henry Bleismer
(Address) 419 S. Washington St

15 Filed MAY 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1922, to May 15, 1922, that I last saw her alive on May 15, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Endarteritis

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Intestinal Paralysis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Diagnostic

(Signed) Adolph C. Eisenberg, M. D.

May 15 1922 (Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL May 17 192[illegible]

20 UNDERTAKER Peter Nicolaus

ADDRESS 2046 Easte[illegible]

TION is very important. See INSTRUCTIONS on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64336 — CERTIFICATE OF DEATH. — 164 D 64336

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (NO. 1135 Hewlett ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Williams

(a) RESIDENCE. NO. 1135 Hewlett ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col.	widow

5a If married, widowed, or divorced (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hagar Barsby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Edward Bryan 1631 Orleans St

15 Filed MAY 16 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 15th May 1922

17

I HEREBY CERTIFY, That I attended deceased from 9 May, 19 , to 15 May, 19 22,

that I last saw h[illegible] alive on 14 " , 19 22,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Heart Failure
Nervous debility,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Mayfield Boyle, M. D.

16th 1922 (Address) 427 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 17 1922
20 UNDERTAKER	ADDRESS 1631 Orleans st
Edward Bryan	

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

64337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 64337

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1715 S. Charles St. St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Nicklas.

(Residence in Baltimore: No. 1715 S. Charles St. St.; yrs. 54 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married.

6-DATE OF BIRTH. June 9th. 1866. (Month) (Day) 1 (Year)

7-AGE. 55 yrs. 11 mos. 5 ds.

If LESS than 1 day. ....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER. (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER. (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Nicklas. (husband)

(Address) 1715 S. Charles St.

15-

Filed MAY 16 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14th. 1922. (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto F. Reinhardt M. D. (Coroner.)

May 15th 192 2. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill DATE OF BURIAL. May 17 1922

20-UNDERTAKER. Wm. E. Evans ADDRESS 1425 E. Baltimore St.

is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64338

90 D 64338

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1059 Harford ave ST.: 10 WARD)

2-FULL NAME Antonia Mantia

(a) RESIDENCE. NO. 1053 Harford ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15-1859

7 AGE 62 Years 5 Months 29 Days | If LESS than 1 day,.. hrs. or.. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Francesco Nicotra

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosalia Sessoms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Francesco Mantia

(Address) 1053 Harford. ave

15 Filed . 19 Registrar

MAY 16 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 15. 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1. 1922, to May. 15 1922, that I last saw h[illegible] alive on May. 14 1922, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Old age.

(duration) yrs. 4. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? no

(Signed) Hubert C. Blake, M. D.

, 19 (Address) 1014 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	5/17 1922
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64339

CERTIFICATE OF DEATH.

90

D 64339

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 874 McKim ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Manuel J. Santos

(a) RESIDENCE. NO. 874 McKim ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 16? yrs. mos. ds. How long in U. S., if of foreign birth? Portugal 16 mo. Bird ds.

(If nonresident give city or town and State) Orland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) September 1880

7 AGE 42 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cape Bird Portugal

PARENTS

10 NAME OF FATHER Julius Santos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portugal

12 MAIDEN NAME OF MOTHER Amelia Santos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portugal

14 Informant Jessie Santos (Address) 874 McKim St-Baltimore

15 Filed Robert P. Harrison, Registrar

MAY 16 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/9, 1922 to 5/13, 1922, that I last saw him alive on 5/9, 1922, and that death occurred, on the date stated above, at 12-30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation over

(duration) ? yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency (duration) yrs. 8 mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. F. Upman, M. D.

, 19 (Address) 1424 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt-Auburn Cem

DATE OF BURIAL May 17 1922

ADDRESS 1725 Ashland Ave Bal

20 UNDERTAKER Mrs Robert-A Elliott

Back of certificates. READ CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64340

D 64340

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718½ W Saratoga ST.; 4 WARD)

2-FULL NAME Maria Adomat

(a) RESIDENCE. NO. 718½ Saratoga ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Adomat

6 DATE OF BIRTH (month, day, and year) Dec 21 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anton Praus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Adomat (Address) 718½ Saratoga St

15 Filed May 16 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17

I HEREBY CERTIFY, That I attended deceased from May 2nd, 1922 to May 14, 1922

that I last saw h[illegible] alive on May 13, 1922

and that death occurred, on the date stated above, at 2 P[illegible] m.

The CAUSE OF DEATH* was as follows:

Intermaniacal Hemorrhage

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 836 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	May 17 1922
20 UNDERTAKER C. W. Dill	ADDRESS 310 N Fred'k Ave.

CAUSE OF DEATH. See instructions on back of TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64341

CERTIFICATE OF DEATH.

D 64341

REGISTERED NO. C 197

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 9 Geo Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geaige Yuby (nevile Hamilton co va) St.; yrs., mos. 4 ds.)

(Residence in Baltimore: No.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col	Sgle

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE. 18 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 18

9-BIRTHPLACE. (State or Country), Va,

PARENTS.

10-NAME OF FATHER, Wilson Yuby.

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Susan Coats

13-BIRTHPLACE OF MOTHER (State or Country), Va,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lennie Ball

(Address) 116 Carlton St

15- Robert P. Harrison, ..., 191.....

16 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 15 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicid 4 pistol shots

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY ..... (Secondary) ..... (Duration) .....yrs.....mos.....ds.

(Signed) ..... (Coroner.) D.

5-16, 1922 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Northumberland Co Va

19-PLACE OF BURIAL OR REMOVAL, Northumberland Co Va

DATE OF BURIAL, May 16 1922

20-UNDERTAKER Geo P. A. Gibson

ADDRESS 573 Lawrence St

CAUSE OF DEATH in plain terms. ... important. See instructions on back of certificate.

D 64342

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

164D 64342

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1602 Mc Culloh St. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laura Virginia Sutton

(Residence in Baltimore: No. 1602 Mc Culloh St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widow

6 DATE OF BIRTH: April (Month) 24 (Day), 1829 (Year)

7 AGE: 73 yrs. 1 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): retired ppp

9 BIRTHPLACE (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: William Diggs

11 BIRTHPLACE OF FATHER (State or country): Wash. D.C.

12 MAIDEN NAME OF MOTHER: Margaret O. Leland

13 BIRTHPLACE OF MOTHER (State or country): Wash D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R. Sutton

(Address) 1735 Bolton St.

15. Robert P. Harrison,

Filed ....., 191 ..... REGISTRAR

Burial Permit Clerk.

6 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 16 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 12, 1922 to May 15 1922

that I saw h[illegible] alive on May 15, 1922

and that death occurred, on the date stated above, at 4:25 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

Arteriosclerosis (Duration) ..... yrs. 1 mos. ..... ds.

Contributory (SECONDARY) Bronchial Catarrh (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) W. B. Rider M. D.

May 16, 1922 (Address) 857 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: May 17, 1922

20 UNDERTAKER: John O. Mitchell ADDRESS 1201 W. Fayette

A. B. EVERY ITEM on this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it may be properly classified, and state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64343

CERTIFICATE OF DEATH.

90 D 64343

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2516 Rayner ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert James Green

(a) RESIDENCE. NO. 2516 Rayner Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Florence Green

6 DATE OF BIRTH (month, day, and year) Nov-28-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46		4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement worker 083

(b) General nature of industry, business, or establishment in which employed (or employer) Construction work

(c) Name of employer Keelty Construction Co.,

9 BIRTHPLACE (city or town) (State or country) Melvale Md.

PARENTS

10 NAME OF FATHER William Green

11 BIRTHPLACE OF FATHER (city or town) Balto County (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant: Florence Green.
(Address) 2516 Rayner ave.

15 Filed 19 Robert P. Harrison, Registrar

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1922, to May 14, 1922, that I last saw him alive on May 14, 1922, and that death occurred, on the date stated above, at 2:43 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. 2 hours mos. ds.

CONTRIBUTORY (Secondary) organic heart disease

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Auscultation

(Signed) Chester Roland, M. D.

5-14, 1922 (Address) 2532 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 16 22
20 UNDERTAKER	ADDRESS
Daniel Gerlach	96 Cem

TION is very important. See instructions on back

D 64344

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 64344

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1501 N Bethel ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Grace E Slivey

(Residence in Baltimore: No. 1501 N Bethel St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 16th, (Month) (Day) 1895 (Year)

7-AGE, 27 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER George G Salisbury

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Selea McDonald

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank E Slivey

(Address) 1501 N. Bethel St

15- Robert F. Harrison,

Filed....., 191.....

Burial Permit Clerk. Registrar.

6 1922

Observe instructions on back of certificate. important. See

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanosis Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, May 17, 1922

20-UNDERTAKER Robt E Turnbull

ADDRESS 1442 N Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64345

) 64345

CERTIFICATE OF DEATH.

129

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Clementine Zemlicka

(Residence in Baltimore: No. Dorguith St. ND Catherdale Ave St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, March (Month) 7 (Day), 1867 (Year)

7-AGE,	If LESS than 1 day,
55 yrs. 2 mos. 9 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Sedlčan Bohemia

PARENTS.

10-NAME OF FATHER, John Zemlicka

11-BIRTHPLACE OF FATHER (State or Country), Sedlčan Bohemia

12-MAIDEN NAME OF MOTHER Antonette Halatka

13-BIRTHPLACE OF MOTHER (State or Country), Sedlčan Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Bromedea

(Address) Notre Dame Dorguith St.

15-

Filed..... Robert P. Harrison, for..... Registrar.

1922 Burial Permit Clerk.

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 11 1922, to May 16 1922, that I saw h.r alive on May 16 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Uremia (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

May 16 1922. (Address) 1106 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md.	May 18, 1922

20-UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St.

Acute attack of an old chronic condition

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 3ks.

D 64346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64346

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Liberty Hgts Av ST., 15 WARD)

2-FULL NAME Mary Ann Jones

(a) RESIDENCE NO. 400 Liberty Hgts Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Edw Joseph Jones

6 DATE OF BIRTH (month, day, and year) Dec 25 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Tyrone Ireland

PARENTS

10 NAME OF FATHER James A Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McCloskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Chas F Bramble
(Address) 400 Liberty Hgts

15 Filed Robert P. Harrison, Registrar
1 8 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1922, to May 15th, 1922,

that I last saw h.. alive on May 15th, 1922,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) senile condition

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Eugene Douglas, M. D.

, 19 (Address) 830 W. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL May 17 1922

20 UNDERTAKER Wm J Tuckerman Sons — ADDRESS N & Pa

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

State of Maryland, City of Baltimore, to wit:

Be it remembered, that on this 29th day of May A. D.,

before me the subscriber, a Notary Public of the said

and for the City aforesaid, personally appeared Marie L. Fleischmann

Aunt of deceased, Arthur Albrecht, Jr.,

and made oath in due form of law that the matters and facts herein contained are true to the

her knowledge, information and belief.

Fred Gaither

Notary Pub

I do hereby make oath that the deceased, Arthur Albrecht, Jr

whose death is recorded on Baltimore City Department of Health

Death Certificate D 64353, is the same as the person known as

Otto Albrecht.

Marie L Fleischm

Aunt.

Spec.--1-10-21--M&T--1500 Bks.

D 64347

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 64347

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Lakewood ST., 6 WARD)

2-FULL NAME Dora Elizabeth White

(a) RESIDENCE NO. 108 N Lakewood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas W. White

6 DATE OF BIRTH (month, day, and year) Nov 29 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edward T White
(Address) 108 N Lakewood

15 Robert P. Harrison, 19 ... Registrar
Burial Permit Clerk.

1 6 1922

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 13, 19 22, to May 15, 19 22,
that I last saw h... alive on May 13, 19 22,
and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Thos B Freeman, M. D.

May 16, 19 22 (Address) 718 N Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL May 17 19 22

20 UNDERTAKER Wm J Rushworth Sons — ADDRESS N Y Pa

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lived here 8 mos.
Came from Woodstock, Vt. Information from Hemsley.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64348

100 001 D 64348

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: No. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albina Kemp.

(a) RESIDENCE NO. 1305 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James C. Kemp

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE Years About 80. Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg (State or country) Virginia

PARENTS

10 NAME OF FATHER Rueben Clements

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Minetree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Bayview Hospital Baltimore Md.

15 Filed MAY 17 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922, to May 16, 1922

that I last saw h alive on May 15, 1922

and that death occurred, on the date stated above, at 3 16 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Goldsmith M.D.

5/16/22 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL May 17 1922

20 UNDERTAKER Joseph L. B Cook ADDRESS 1003 W Baltimore St.

CAUSE OF DEATH. See instructions on back of Certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64349

CERTIFICATE OF DEATH.

60-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Lewis

(a) RESIDENCE NO. 2559 Edmondson Av. ST., WARD Piedmont W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. — mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie B Lewis

6 DATE OF BIRTH (month, day, and year) Apr 26-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40 yrs.	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs. Savage

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do Not Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles Lewis (Address) 2559 Edmondson Av

15 MAY 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-28, 1922, to 5-16, 1922

that I last saw him alive on 5-16, 1922

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tapering of the pupil Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-15-22.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Caldwell M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Piedmont West Virginia

DATE OF BURIAL May 17 1922

20 UNDERTAKER Geo. Weber & Son

ADDRESS 3 Edmondson

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64350

CERTIFICATE OF DEATH.

185 D 64350

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3408 E. Fairmount Ave WARD 76)

2-FULL NAME Margaretha Kellermann

(a) RESIDENCE NO. 3408 E. Fairmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav Kellermann

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Strumsdorfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Frederick Kellermann
(Address) 3408 E. Fairmount Ave

15 Filed MAY 17 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to May 15, 1922

that I last saw her alive on May 14, 1922

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Fracture of Leg

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. S. Neer, M. D.

5/16/22 (Address) 408 S Pat Okla

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL May 17 1922

20 UNDERTAKER H. Sonder Sons ADDRESS 1210 Park Ave.

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64351 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64351

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 60 Darby St. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Boston

(Residence in Baltimore: No. 60 Darby St. St. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Apr. (Month) 22 (Day) 1870 (Year)

7-AGE, 52 yrs. mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George W Murphy

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Boston

(Address) 60 Darby St

15- MAY 17 1922 191.... ROBERT R. KRAUTER, Filed....., Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 15th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15th 1922, to May 15th 1922, that I saw h[illegible] alive on May 15th 1922, and that death occurred, on the date stated above, at [illegible] m.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Chr. Interstit. Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(Duration) yrs. mos. ds.

(Signed) Geo. W. Brod M. D.

5/16/22, 191.., (Address) 2404 Md. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, May 18 1922

20-UNDERTAKER Cheshire & Son — ADDRESS Chestnut Ave

important. See instructions on back of Certificate.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64352

CERTIFICATE OF DEATH.

164 D 64352

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2624 Hampden ave St., 17 WARD)

2-FULL NAME Margaret Kneller

(a) RESIDENCE NO. 2624 Hampden ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Kneller

6 DATE OF BIRTH (month, day, and year): Aug 12 1840

7 AGE: Years 81 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Adam Merkel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Menchey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): L K Armentrout 2624 Hampden ave

15 Filed MAY 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1922, to May 16, 1922, that I last saw h alive on May 13, 1922, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Duration) 3 yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine examined

(Signed) R B Norment M. D.

5/16, 1922 (Address) 3343 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manchester Md

DATE OF BURIAL: May 18 1922

ADDRESS .....

20 UNDERTAKER: Chenoweth & Son Westmt ave

CAUSE OF DEATH. See instructions on back of CERTIFICATE. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64353 D 64353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 842 W. Baltimore St. REGISTERED NO. C

CITY OF BALTIMORE: (No. 18 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Albrecht jr. (Otto Albrecht)

(Residence in Baltimore: No. 842 W. Baltimore St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August (Month) 28 (Day), 1884 (Year)

7-AGE, 37 yrs. 8 mos. 17 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Florist
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Brooklin N. Y.

PARENTS.

10-NAME OF FATHER, Arthur Albrecht.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lena Kopp.

13-BIRTHPLACE OF MOTHER (State or Country), Brooklin N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Fleischmann

(Address) 947 Coldspring Lane

15- Filed MAY-17 1922, 191 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 15th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 13. 1922, to May 15. 1922, that I saw him alive on May 15. 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions (epileptic)

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Encephalitis

(Duration) — yrs. — mos. 4 ds.

(Signed) F. J. Lebold M. D.

May 15., 1922, (Address) 1101 Edgecombe Cir.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Brooklyn N Y.

19-PLACE OF BURIAL OR REMOVAL, London Park. DATE OF BURIAL, May. 18., 1922.

20-UNDERTAKER C. W. Dill ADDRESS 3109 Frederick Ave,

CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64354

REGISTERED NO. 90 D 64354

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Hebrew Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Davis

(a) RESIDENCE. NO. 106 N Kenwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28-94

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse 048

(b) General nature of industry, business, or establishment in which employed (or employer) Hebrew Hosp

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Jefferson Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosa Hyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Jefferson Davis
(Address) 106 N. Kenwood Ave

15 Filed MAY 17 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6 1922 to May 15 1922 that I last saw her alive on May 15 1922 and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Cardiac decompensation

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Zinten M. D.

5/15/22 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL May 18 1922

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64355

CERTIFICATE OF DEATH.

101 D 64355

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; WARD)

2-FULL NAME Mrs. Wolfe Hordy (Hardy)

(a) RESIDENCE. NO. 712 N. Bradford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mamie Hardy

6 DATE OF BIRTH (month, day, and year) May 31-79

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Bidlingmayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Jennie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Mamie Hardy

(Address) 712 N. Bradford

15 Filed MAY 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 15, 1922, that I last saw h~~im~~ alive on May 15, 1922, and that death occurred, on the date stated above, at 7.00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia - Both Lungs

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Ed Ginsberg, M. D.

5/16, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 18 1922
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
100 D 64356

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Ashburton Ave ST. 16 WARD)

2-FULL NAME Joseph Merrican Tucker.

(a) RESIDENCE. NO. 1029 Ashburton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan - 2 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Merrican Tucker.

11 BIRTHPLACE OF FATHER (city or town) Elkridge
(State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie Estella Thomas.

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co.,
(State or country) Md.

14 Informant Minnie Estelle Tucker.
(Address) 1029 Ashburton Ave.

15 Filed MAY 17 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 15 - 1922

17 I HEREBY CERTIFY, That I attended deceased from 5 - 7 -, 1922, to 5 - 15 -, 1922, that I last saw h.im alive on 5 - 15 -, 1922, and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? examination

(Signed) Chester Riland., M. D.

5-15, 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 17 1922
20 UNDERTAKER George L. Schmidt	ADDRESS 2101 Eutaw Ave

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

D 64357 HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. D 64357

1-PLACE OF DEATH St. Agnes Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 70 ..... WARD)

2-FULL NAME Baby ~~Mahlstead~~. Hoffman

(a) RESIDENCE NO. 2031 Dulaney St ..... ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town und State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/15/22.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 20 min.
	—	—	—	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Gordon Hoffman.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Marie V. Mahlstead

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Gordon Hoffman.
(Address) 2031 Dulaney St

15 MAY 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 15, 1922, that I last saw him alive on May 15, 1922, and that death occurred, on the date stated above, at 12.30 P m. lived 30 mins

The CAUSE OF DEATH* was as follows:

premature labor.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) injury to mother-fall.

..... (duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. W. Scott, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 18 1922
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Eutaw Pl.

CAUSE OF DEATH must be filled in ... TION is very important. See instructions on back of certificate.

Spec.—6-9-15—H. P. Co.—1000 Bks.

D 64358

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64358

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 E. Baltimore ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Crook

(a) RESIDENCE. NO. 1317 E. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Crook

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Fowler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Geo. W. Habbersett
(Address) 2501 Raslyn Ave.

15 FILED MAY 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1921, to May 14, 1922, that I last saw h[illegible] alive on May 13, 1922, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 9/12 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) Several years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. H. Hartman, M. D.

May 15, 1922 (Address) 2314 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	May 17 1922
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

D 64359 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64359

CERTIFICATE OF DEATH. X 90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 86 Russell St W Mun ST., 25 WARD)

2-FULL NAME Hattie E Parks

(a) RESIDENCE NO. 86 Russell St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colrd

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Parks

6 DATE OF BIRTH (month, day, and year) November 1874

7 AGE Years 48 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick (State or country) Md

PARENTS

10 NAME OF FATHER David Downes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane Lee

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Md

14 Informant Cora M. Porter (Address) 1417 Division

15 Filed MAY 17 1922 19.... ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CAUSE OF DEATH (Fill in plain words. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13- 1922

17 I HEREBY CERTIFY, That I attended deceased from 2-3, 1922, to May 13, 1922, that I last saw h[illegible] alive on May 13, 1922, and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Hall M. D.

, 19 (Address) Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL May 19 22

ADDRESS

20 UNDERTAKER Samuel Hemsley Balto

Spec.—1-10-21—M&T—1500 Bks.

D 64360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64360

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH #

CITY OF BALTIMORE: (No. 1141 N. Saratoga ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine M Daniels

(a) RESIDENCE NO. 1141 N. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fem	colored	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of John M Daniels

6 DATE OF BIRTH (month, day, and year) June 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House maid 970

(b) General nature of industry, business, or establishment in which employed (or employer) General housework

(c) Name of employer Mr Large, Baltimore

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Blossom

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sarah Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mollie James (Address) 1141 N. Saratoga St.

Filed MAY 17 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 16, 1922,

that I last saw h— alive on May 16, 1922,

and that death occurred, on the date stated above, at 10-30 m.

The CAUSE OF DEATH* was as follows:

Chronic Pyelonephritis

nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) a General debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Bernard L Emmert, M. D.

5/17, 1922 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 1922

20 UNDERTAKER Samuel Hemsley

ADDRESS 3[illegible] Balto

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

D 64361

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D 64361

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 E. Biddle ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Jane Conghlan

(Residence in Baltimore: No. 1618 E Biddle St. St.; 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Nov. (Month) 30 (Day) 1851 (Year)

7-AGE: 70 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: William Robinson

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Eliza May

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret A. Robinson

(Address) 1618 E. Biddle St.

15- MAY 17 1922 J. E. Weber

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July, 1921, to, May 15 1922, that I saw h[illegible] alive on May 15 1922, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY) Pulmonary Oedema

(Duration) yrs. mos. 2 ds.

(Signed) J. E. Webster M. D.

5/17, 1922 [Address] 1009 Cathedral

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: May 18 1922

20-UNDERTAKER: Wilbur W. Shriver

ADDRESS: 1018 Edmondson Ave

state CAUSE OF DEATH
TION is very important. See instructions on back of certificate.

D 64362 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64362

CERTIFICATE OF DEATH.

REGISTERED No. C 165

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Hartlove

(Residence in Baltimore: No. 714 W. Fayette St- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: John Ryan

11-BIRTHPLACE OF FATHER (State or Country): Canada

12-MAIDEN NAME OF MOTHER: Charlotte Lee

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Martin

(Address) 318 N Bacon St

15-MAY 17 1922 Filed, 191 J. C. Wilson Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 15 (Day), 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach, Following Poisoning by Mercury Bichloride

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Probably Suicide

(Duration) yrs. mos. 4 ds.

(Signed) W. K. Gordon M. D. (Coroner.)

5-15-, 1922 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, 5-18-, 19

20-UNDERTAKER Chas. S. Wauchope & Son ADDRESS 118 W. Mt. Royal Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

462 D. 64363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jones

(a) RESIDENCE NO. 1370 N. Freemont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Hurd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed MAY 17 1922 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 13, 19 22, to May 14, 19 22,
that I last saw her alive on May 14, 19 22,
and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma of Breast —

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Brumbach, M. D.

5/15/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 17 1922
20 UNDERTAKER Edward Ruggold	ADDRESS 1463 Carey St.

CAUSE OF DEATH. See instructions on back of Certificate. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001.

REGISTERED NO. D 64364

1-PLACE OF DEATH D 64364

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Barrocca

(a) RESIDENCE. NO. Municipal Tuberculosis Hospital ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) May 12, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, 11 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Barrocca

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Rosaria Sessa

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant (Address) Municipal Tuberculosis Hospital records JOHNS HOPKINS HOSPITAL

15 Filed MAY 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1922. to May 13, 1922.
that I last saw her alive on May 13, 1922.
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Asphxia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frances L. Sadaglia M. D.

5-13-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAY 16 1922

20 UNDERTAKER

ADDRESS

Commissioner Health.

CAUSES OF DEATH. See instructions on back of certificate. ATTENTION is very important.

58

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 64365

REGISTERED NO. D 64365

1-PLACE OF DEATH D 64365

CITY OF BALTIMORE: (NO. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Long

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Michael Long

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed MAY 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 23, 19 22, to May 12, 19 22, that I last saw him alive on May 11, 19 22, and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

5/16/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL MAY 16 1922

20 UNDERTAKER: Health Commissioner Health,

ADDRESS

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

88

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64366

D 64366

CERTIFICATE OF DEATH.

REGISTERED NO. 174

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Davis

(a) RESIDENCE NO. Levering House ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Toney Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records, (Address) Municipal Hospital. UNIVERSITY OF MARYLAND

15 MAY 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 5, 19 22, to May 11, 19 22, that I last saw h[illegible] alive on May 10, 19 22, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

10 yrs

Arteriosclerosis. Cerebral Hemorrhage / week

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) - yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde O'Neill M. D.

5/11/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL MAY 1[illegible] 1922

20 UNDERTAKER Commissioner Health,

ADDRESS

per. Wm. [illegible]

CAUSE OF DEATH. See instructions on back of Certificate. ATION is very important.

(6)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 64367

D 64367

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Tillman

(a) RESIDENCE NO. None ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) D+D

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER John Tillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,

(Address) Municipal Hospital. UNIV

15 Filed MAY 17 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to May 14, 1922, that I last saw h im alive on May 14, 1922, and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Mowell, M. D.

5/15/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL MAY 1 1922

20 UNDERTAKER Commissioner Health,

ADDRESS

... W. E. WOODALL

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64368

160 D 64368

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Johnson ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas S. Brophy

(a) RESIDENCE. No. 1728 Johnson ST.: 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 10 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Robt L. Brophy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Ditz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robt L. Brophy
(Address) 1728 Johnson St.

15 MAY 17 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922, to May 17, 1922.

that I last saw h[illegible] alive on May 16, 1922.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Mal Nutrition

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Campbell M. D.

May 17, 1922 (Address) 1644 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C. A. Co.	May 17, 1922
20 UNDERTAKER Margaret E. Lynn	ADDRESS 1417 Eutaw St.

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64369

CERTIFICATE OF DEATH.

31 D 64369

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosaria Barrocca

(a) RESIDENCE. No. 105 Springer st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joe Barrocca

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Mike Besser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Frieda Di Maro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Hospital Records M.T.H.

15 Filed 5-17-1922 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1922, to May 16, 1922, that I last saw h er alive on May 16, 1922, and that death occurred, on the date stated above, at 5.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dalrymple M. D.

5-16-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Holly Hedgemere Co.

DATE OF BURIAL May 18 1922

20 UNDERTAKER Lilly & Zeile

ADDRESS 1035 S. Wolfe

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64370

CERTIFICATE OF DEATH.

D 64370

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Penn ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E Aelman

(Residence in Baltimore: No. 219 Penn St.; 65 yrs., 2 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 15, 1857 (Month) (Day) (Year)

7-AGE, 65 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carriage Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Leonhard Bros.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Fred Aelman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Aelman

(Address) 219 Penn St

15-

Filed ..... 191.. Robert P. Harrison, Registrar.

1 7 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 15, (Day) 1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12th 1915, to May 15th 1915, that I saw h[illegible] alive on May 14th 1915 and that death occurred, on the date stated above, at 2.00 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis & Cirrhosis of Liver (Duration) ... yrs. 2 mos. 3 ds.

(Signed) F. P. Constitors M. D.

5/17/ 191.. (Address) 654 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, May 18, 1915

20-UNDERTAKER Geo Leinbach & Sons — ADDRESS 617 N Gay St

Important: Do not write above this line.

D 64371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64371

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH: Body found in the water at the Foot of Hanover St. (No. 92 Ward)

City of BALTIMORE:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Willian S. Dunn. 2

(Residence in Baltimore: No. 214 E. Montgomery St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. June 18th. 1876. (Month) (Day) (Year)

7-AGE. 45 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Penna.

PARENTS.

10-NAME OF FATHER. Francis J. Dunn.

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Sarah Noel.

13-BIRTHPLACE OF MOTHER. (State or Country). Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry C. Dunn. (brother)
(Address) 3225 N. Sergeant St. Philadelphia, Pa.

15- Robert P. Harrison,

Filed ..... 192.....

Burial Permit Clerk. Registrar.

7 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Missing May 11th. 1922. Body found May 15th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

May 17th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Gulden's Sta. Adams Co. Pa. Via W. Md. R.R. DATE OF BURIAL. May 18 1922

20-UNDERTAKER. John F. Denny ADDRESS 715 Light St

is very important. See that every

Spec.—1-10-21—M&T—1500 Bks.

D 64372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64372

CERTIFICATE OF DEATH

REGISTERED NO. 58

1-PLACE OF DEATH Municipal Hospital ST., WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Hugh McKibbin

(a) RESIDENCE NO. Bay View ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 58 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): La.

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant (Address): Hospital Records

15 1922 Robert P. Harrison, Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1922

17 I HEREBY CERTIFY That I attended deceased from May 15, 1922 to May 16, 1922

that I last saw him alive on May 16, 1922

and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Re hoperitoneal Hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

19 1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: May 18 1922

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

TION is very important. See instructions on BACK OF CERTIFICATE

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64373

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 Ettting ST.: 14 WARD)

2-FULL NAME John Wilson Cotton.

(a) RESIDENCE. No. 1925 Ettting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 Cety yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Marr[illegible]

5a If married, widowed or divorced HUSBAND of (or) WIFE of Bessie Cotton.

6 DATE OF BIRTH (month, day, and year) Sept 14, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Harrelson Painting

9 BIRTHPLACE (city or town) (State or country) Quantico Wicomico Co. Md

PARENTS

10 NAME OF FATHER Littleton Cotton

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Phoeba Adams

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Bessie Cotton

(Address) 1925 Ettting

15 Filed MAY 17 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1922 to May 16, 1922

that I last saw h[illegible] alive on May 16, 1922

and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Urinary.

(Signed) Wm. N. Wright, M. D.

May 16, 1922 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Quantico Wicomico Co. Md

DATE OF BURIAL May 19 1922

20 UNDERTAKER George H Holland

ADDRESS 1631 Ursula Ave

I. B.—[illegible] mation should be carefully supplied. AGE should be stated. Indefinite CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64374

D 64374

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Brown

(a) RESIDENCE NO. 1137 Myrtle Ave ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Florence Brown

6 DATE OF BIRTH (month, day, and year) Feb 14, 1867

7 AGE: Years 55 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant (Address) Mercy Hospital Records

~~Robert A. Harrison,~~

15 1922 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922 to May 17, 1922 that I last saw him alive on May 17, 1922, and that death occurred, on the date stated above, at 3:20a.m.

The CAUSE OF DEATH was as follows:

Ruptured gangrenous appendix

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

Toxemia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home 5/8/22

Did an operation precede death? yes Date of 5/14/22

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John J. Crum, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemty — DATE OF BURIAL 5-21 1922

20 UNDERTAKER: George H. Holland — ADDRESS 1691 W. Lexington

CAUTION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64375

CERTIFICATE OF DEATH.

D 64375

REGISTERED NO. .....

1-PLACE OF DEATH Baltimore Md'

CITY OF BALTIMORE: (NO. 424 Mosher ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Page Harper.

(a) RESIDENCE. NO. 424 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Abedith Warr

6 DATE OF BIRTH (month, day, and year) Nov 12-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Buckingham Virginia

PARENTS

10 NAME OF FATHER Abedith Warr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Gertrude E. Wright (Address) 424 Mosher St

15 Robert P. Harrison, Registrar

7 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 — 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24th, 1922, to May 14th, 1922, that I last saw h.. alive on May 14th, 1922, and that death occurred, on the date stated above, at 11 — a — m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease Valvular

(duration) 4 yrs. perhaps Longer mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 2 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of

Was there an autopsy? No only

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. Bunnell Taylor, M. D.

, 19 (Address) 746 Dulaney St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-18 1922

20 UNDERTAKER George H. Holland ADDRESS 169 Druid Hill Ave

TION is very important. See instructions on back

D 64376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64376

CERTIFICATE OF DEATH.

REGISTERED No. C 64376

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Homewood Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Kliem

(Residence in Baltimore: No. Ruxton Road & Locust Ave. Ruxton, Md. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Jan. 18th, 1877
(Month) (Day) (Year)

7-AGE 45 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: At home (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Kliem

(Address) Ruxton, , Md.

15- Robert P. Harrison, M.D. Registrar.

MAY 17 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May, 14th. 1922., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries received in Auto accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner.)

May 17 1922 (Address) 3602 Bolton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross A.A. Co

DATE OF BURIAL, 5/18/22, 19....

20-UNDERTAKER Chas. F. Evans & Son- 118 W.

ADDRESS Mt. Royal Ave.

CAUSE OF DEATH: In plain English, and as important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(Marya ... Brown)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64377

CERTIFICATE OF DEATH.

3/ D 64377

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2426 - E - Lafayette St.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret A Brown

(Residence in Baltimore: No. 2426 - E - Lafayette St.; 57 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH. March 18, 1880
(Month) (Day) (Year)

7-AGE, 42 yrs. 2 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 037
(b) General nature of industry, business, or establishment in which employed (or employer). Housewife

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, John Poston

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Brown

(Address) 2426 E. Lafayette ave

15- Robert P. Harrison,

Filed ..., 191...

~~Burial Permit Clerk.~~ Registrar.

1 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922, to May 15 1922, that I saw h alive on May 15 1922, and that death occurred, on the date stated above, at 11 15 m.

The CAUSE OF DEATH* was as follows:

I. Luetin + T. Pneumonia

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuber-

Cardiac (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

May 16 1922 (Address) 2106 Harford ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, May 18, 1922

20-UNDERTAKER Richard H. Cuskey

ADDRESS 438 E. 40th ave

Important. See instructions on reverse side.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Genevieve Quinn)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64378

D 64378

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 W. Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genvie Quinn

(a) RESIDENCE. NO. 07 W. Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Sing l e

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	20	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Embroider 069

(b) General nature of industry, business, or establishment in which employed (or employer) Needle Work

(c) Name of employer Mrs. Scott

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nora Quinn (Address) 17 W. Preston

15 Robert F. Harrison Registrar

Burial Permit Clerk.

T 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1 1922, to May 15 1922

that I last saw h er alive on May 15 1922

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Edgar P. Sandrock M. D.

19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 18 1922
20 UNDERTAKER	ADDRESS
Martin Flaherty & Son	1807 N North

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 64379

D 64379

CERTIFICATE OF DEATH.

155

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp. Baltimore (WARD)

2-FULL NAME John Kutchemeister

(a) RESIDENCE. No. 304 Patapsco, ave. St. Helena - Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life - mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~ Married, ~~Widowed~~, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louisa Kutchemeister

6 DATE OF BIRTH (month, day, and year) Jan 4 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25 yrs -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electric Welder -

(b) General nature of Industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md -

PARENTS

10 NAME OF FATHER John Kutchemeister Sr,

11 BIRTHPLACE OF FATHER (city or town)... md -
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hesler

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Hospital Records -
(Address) Lombard & Green Sts

15 Filed Robt P. Harrison, Registrar
1 7 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 17 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922, to May 17, 1922,
that I last saw him alive on May 17, 1922,
and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:
Osteomyelitis of dorsal + lumbar vertebrae + sacrum

(duration) yrs 6 wks, ds.

CONTRIBUTORY (Secondary) Not Known -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 304 Patapsco Ave. St Helena Md.

Did an operation precede death? yes - Date of April 22, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

5/17, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 20 1922
20 UNDERTAKER William Cook	ADDRESS 502 E Wash Ave

TION is very important. See instructions on back

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute condition.
No further history

Spec. 6-3-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64380

D 64380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 129

CITY OF BALTIMORE: No. 8 E. Belvedere Ave. ST. Pimlico (WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bauers.

(a) RESIDENCE. No. 8 E. Belvedere Ave. Pimlico. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Bauers

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) "
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Mayme I. Olcott, 8 E. Belvedere Ave.

15 Filed May 19 1922 Robert F. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1922, to May 17, 1922, that I last saw h[e] alive on May 16, 1922, and that death occurred, on the date stated above, at 12-20 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 6' yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis & nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Leute, M. D.

5/17, 1922 (Address) 7040 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	May 19, 22

20 UNDERTAKER William Cook ADDRESS 502 E. North Av

TION is very important. See instructions on back of certificate.

7 1922

Spec.—1-10-21—M&T—1500 Bks.

Sonne - Gemind & Litb. Hlw.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64381

CERTIFICATE OF DEATH.

D 64381

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 Aruna Av ST., 16 WARD)

2-FULL NAME Macon Robb Stone

(a) RESIDENCE NO. 2414 Aruna Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida. Stone

6 DATE OF BIRTH (month, day, and year) July 28 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder 6/6

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm B. Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Edgar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida. Stone

(Address) 2414 Aruna Av

15 Filed May 17, 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12 1922 to April 16 1922

that I last saw h alive on April 12 1922

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis

(duration) 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter Stone, M. D.

5/16 1922 (Address) 3 E 39th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 18 1922

20 UNDERTAKER Wm Cook — ADDRESS 3 E 39th St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64382

D 64382

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH U.S. Veterans Hospital #56,

CITY OF BALTIMORE: (No. Baltimore, Md. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eymond Carter

(a) RESIDENCE NO. 526 Greenwillow St., Baltimore, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Male	Black	Single

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) --

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address) Ft. McHenry, Md.

15 Filed MAY 18 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 16, 1922, that I last saw him alive on May 16, 1922, and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis chronic pulmonary moderately advanced and active

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? --

What test confirmed diagnosis? Physical exam. only

(Signed) J. A. Foster BCM Surgeon U.S. M. D.

May 18 1922 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL May 18 1922

20 UNDERTAKER Rol Fenneman & Bro

ADDRESS 427 E. Baltimore St.

CAUSE OF DEATH. See instructions on back of Certificate. TION is very important.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64383

CERTIFICATE OF DEATH.

161-91 64383

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Sergeant ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant child of Elmer & Gertrude Inmon

(a) RESIDENCE. No. 1207 Sergeant ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, / hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None / 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Elmer Inmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Gertrude Shields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Elmer Inmon
(Address) 1207 Sergeant St.

15 Filed MAY 18 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922, to May 16, 1922, that I last saw h[illegible] alive on May 16, 1922, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Prematur Birth

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

May 19, 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: May 18 1922

20 UNDERTAKER: John F. Gowan Jr Lee F. Gowan

ADDRESS: 901 Fallsway

CAUTION—IT IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64384 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64384

CERTIFICATE OF DEATH. 38

1-PLACE OF DEATH Municipal Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 15 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Price

(a) RESIDENCE (Usual place of abode) No. 130 Lauren ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hosp Records (Address)

15 Filed MAY 18 1922 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-7 1922 to 5-16 1922 that I last saw him alive on 5-16 1922 and that death occurred, on the date stated above, at 6.58 P m.

The CAUSE OF DEATH* was as follows:

Septicitis Aortic Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Clyde M. Snell M. D.

5/17 1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL May 18th 1922

20 UNDERTAKER Joseph A Farrell — ADDRESS 2314 Pinkney

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 64385

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Grayson ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine D Scheytt

(a) RESIDENCE. NO. 3031 Grayson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Godfrey Scheytt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Rindstock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia E Schettich

(Address) 335 N. Gay St.

15 Filed ....., 19.... ROBERT R. KRAUTER Registrar

MAY 18 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to May 16, 1922, that I last saw h[illegible] alive on May 16, 1922, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) abt month yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank N. Hills, M. D.

19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 19 1922

20 UNDERTAKER: Mrs. Mrs John H Teufel & Son — ADDRESS: 80 W. Fayette St.

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64386

D 64386

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mercy Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley L. Reibert

(a) RESIDENCE. No. 1733 N. Smallwood ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 11, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cato, Md

PARENTS

10 NAME OF FATHER Wm. H. Reibert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cato Md

12 MAIDEN NAME OF MOTHER Nannie Sarreck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William H. Reibert
(Address) 1733 N. Smallwood St

15 Filed MAY 18 1922 19 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1922, to May 17, 1922, that I last saw her alive on May 17, 1922, and that death occurred, on the date stated above, at 5a. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus
Peritonitis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of May 15, 1922

Was there an autopsy? no

What test confirmed diagnosis? Finding Physical Signs

(Signed) John J. Ferris M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 19th 1922
20 UNDERTAKER	ADDRESS
Mrs. Mrs J. H. Tenbel & Sons	1 W. Fayette

CAUSE OF ... TION is very important. See instructions on back ...

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Appendix involved.
Appendix removed.

D 64387

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 64387

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 1/2 Rossbach Court, St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Johnson, (C) 42 ---------

(Residence in Baltimore: No. 15 1/2 Rossbach Court. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	Colored.	Single

6-DATE OF BIRTH. Do not know. (Month) (Day) 1..... (Year)

7-AGE. 42 yrs. ---------- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Johnson, (C)

11-BIRTHPLACE OF FATHER, (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Reed, (C)

(Address) 729 Grindall Ct.

15- Filed MAY 18 1922 ROBERT R. KRAUTER, Burial Permit Clerk..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 16th. 1922. (Month) (Day) 192..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

May. 17. 22 (Address) 917 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
at allen	5/18/ 1922

20-UNDERTAKER.	ADDRESS
R L Paban	220 w Mulberry

Is very important. See instructions

Spec.—1-10-21 M&T 1500 Blks.

D 64388 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 ✓ 31 D 64388

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 Druid Hill Ave ST., 14 WARD)

2-FULL NAME Mary C Lee,

(a) RESIDENCE NO. 1730 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	37	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Chas Lee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Robt Lee
(Address) 1730 Druid Hill Ave

15 MAY 18 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922 to May 16, 1922

that I last saw her alive on May 16, 1922

and that death occurred, on the date stated above, at 7.45 P.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lung,

Tuberculosis of Lung (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lung (duration) yrs. 7 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Health Department

(Signed) Dr. H. W. Kennedy M. D.

5-17 1922 (Address) 705 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL May 19 1922

20 UNDERTAKER Edmund C Wright — ADDRESS 364 N Carey

IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64389

CERTIFICATE OF DEATH.

101-001 D 64389

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 505 Summerset ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Pulley.

(a) RESIDENCE NO. 505 Summerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Pulley

6 DATE OF BIRTH (month, day, and year) June 5 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	41	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Pulley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Pulley

(Address) Chase Md

15 Filed MAY 18 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17 19 22

17

I HEREBY CERTIFY, That I attended deceased from 5-16, 1922, to 5-17, 1922,

that I last saw him alive on 5-17-, 1922,

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chase Md. DATE OF BURIAL May 20 1922

20 UNDERTAKER Hammett & Wright ADDRESS 136 McCaney

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(5-5-85 Sup 64390)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64390

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Schlissel

(a) RESIDENCE. NO. 462 Williams St N.W. City WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Esther Schlissel

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Lucil Schlissel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Fannie Annotts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 MAY 18 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9 - 1922 to May 17, 1922

that I last saw him alive on May 17 - 1922

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Brain tumor

Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 17/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lucile Holman, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City N.Y.

DATE OF BURIAL 5/18 1922

20 UNDERTAKER Jack Lewis 1439 E Balto

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~15 2 76~~ ~~D 64391~~ D 64391

CERTIFICATE OF DEATH.

K 74/001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie Haas

(a) RESIDENCE. NO. Monroe, Louisiana WARD.

(Usual place of abode) (If nonresident give city or ~~town and State~~)

Length of residence in city or town where death occurred ~~yrs.~~ Unknown ~~mos.~~ 2 ~~ds.~~ How long in U. S., if of foreign birth? ~~yrs.~~ ~~mos.~~ ~~ds.~~

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs H. Herfeld (Daughter) Glen Arbor, Monroe, Louisiana

6 DATE OF BIRTH (month, day, and year): Mch 26/1864

7 AGE: Years 58 Months 1 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Mayer Halm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Mintzenheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 MAY 18 1922 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 17, 1922, that I last saw her alive on May 17, 1922, and that death occurred, on the date stated above, at 5.30 A. p. m.

The CAUSE OF DEATH* was as follows:

Death sudden, not cause not determined probably a cerebral hemorrhage.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hepatic cirhosis & ascites & jaundice (duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 15

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) K. I. Meyer, M. D.

, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Crematory — DATE OF BURIAL: May 19 1922

20 UNDERTAKER: Dando Sondheim — ADDRESS: 114 W. Mt. Royal

TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Approved. A. L. Sweet

March 7, 22

Spec.—1-10-21—M&T—1500 Bks.

D 64392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64392

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4015 Maine Ave. 15 WARD)

2-FULL NAME Lewis H. Nachman

(a) RESIDENCE NO. 4015 Maine Ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada W. Nachman

6 DATE OF BIRTH (month, day, and year): Sept. 26, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mnfg. Ice Cream Cones

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Henry Nachman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mina Haymanrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. L. Nachman

(Address): 4015 Hamilton Maine Ave.

15 Filed MAY 18 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 17 1922, to May 17 1922, that I last saw him alive on May 17 1922, and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

Immediate (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Symptoms

(Signed) A. C. Emmert, M. D.

May 17 1922 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cem.

DATE OF BURIAL: 5/19 1922

20 UNDERTAKER: David Sondheim

ADDRESS: 118 W. Mt. Royal Ave.

CAUSE OF DEATH. See instructions on back of certificate. IMPORTANT is very important.

Spec.—6-9-17—H. P. Co.—1000 Bks.

D 64393 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

173 D 64393

REGISTERED NO.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Bon Ste. St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard Burrier

(a) RESIDENCE. NO. 11 Union ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Burrier

6 DATE OF BIRTH (month, day, and year) 8/17/857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer . 031

(b) General nature of industry, business, or establishment in which employed (or employer) Wilson & Martin Abbattior

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER E. D. Burrier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Angelina Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Millard Burrier (deceased)
(Address)

15 Filed MAY 18 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16 19 22

17 I HEREBY CERTIFY, That I attended deceased from 5/15, 19 22, to 5/16, 19 22,

that I last saw h.. alive on 5/16/22, 19

and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

Cholelithiasis - co

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 11 Union St

Did an operation precede death? Yes Date of 5/16/22

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) Wm. H. Douglas Md M. D.

May 16" 1922 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 19" 22
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Ballo St

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64394 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64394

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Dilger

(a) RESIDENCE (Usual place of abode) NO. 729 Greenmount Ave. WARD. Connecticut

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer The Automatic Lighting Co.

9 BIRTHPLACE (city or town) (State or country) Connecticut -

PARENTS

10 NAME OF FATHER John Delger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) St. Vincent. 831 Greenmount Ave.

15 MAY 18 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to May 18, 1922

that I last saw him alive on May 18, 1922

and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio-pneumonia.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. R. Jones. M. D.

5/ 14. 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Thomason Comm	May 19 19 22
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 blks.

64395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64395

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~1631~~ 1613 Lamont Ave. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edda T. Wallace

(a) RESIDENCE NO. ~~1631~~ 1631 Lamont ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of — (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER: Bernard J. Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lillian Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Bernard J. Wallace

(Address) 1631 Lamont ave.

15 MAY 18 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1922

17 I HEREBY CERTIFY, That I attended deceased, from April 27, 1922, to May 17, 1922, that I last saw her alive on May 17, 1922, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Broncho pneumonia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) David Riecke M. D.

, 19 (Address) 1506 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: May 19 1922

UNDERTAKER: George J. Rutt

ADDRESS: 1730 Harford Ave.

CAUSES OF DEATH. See instructions on back of certificate. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

From history from parents child probably had measles about three weeks prior to Dr. Miller's attendance

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64396

D 64396

CERTIFICATE OF DEATH.

179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 W. Fayette St. 19 WARD)

2-FULL NAME Fannie. W. Addison

(a) RESIDENCE NO. 1519 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. c mos. c ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew K. Addison

6 DATE OF BIRTH (month, day, and year) May 27 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	c	c	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernard H. Mat[illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Gerwig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catonsville Md

14 Informant Andrew K. Addison (Address) 1519 W. Fayette St

15 MAY 18 1922 ROBERT A. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to May 16, 1922.

that I last saw h[illegible] alive on May 10, 1922

and that death occurred, on the date stated above, at 5-00 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Cerebral Embolism

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Hypertrophied Heart

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) C. Urban Arnett, M. D.

(Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 19 1922
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 E. Pra.

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Steinwedel. ✓

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 29 D 64397

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 449 Augusta Av ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Steinwedel

(a) RESIDENCE. NO. 449 August Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. — mos. — ds. How long in U. S., if of foreign birth? 87 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Steinwedel

6 DATE OF BIRTH (month, day, and year): Dec 9 1834

7 AGE: Years 87 Months 5 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm. Steinwedel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Henry Hackett 449 Augusta Ave

15 MAY 18 1922 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May, 1910, to May 17, 1922

that I last saw her alive on May 17, 1922

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No

Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W. Jones, M. D.

May 7, 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 20 1922

20 UNDERTAKER: Robert L. Little — ADDRESS: 2700 Edmondson Av

TION is very important. See instructions on back of certificate.

Spec. 4-910 H. P. Co.—1000 Bks.

64398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64398

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Calhoun ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Randall

(a) RESIDENCE. No. 917 Calhoun ST., WARD.

(Usual place of abode) Same

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: Col. | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon Randall.

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 26 | Months + | Days + | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Solomon Randall 917 Calhoun St

15 Filed MAY 18 1922 . 19 Registrar: J. C. Wilson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1922

17

I HEREBY CERTIFY, That I attended deceased from May 3 . 1922. to May 16 . 1922.

that I last saw her alive on May 15 . 1922

and that death occurred, on the date stated above, at 8.20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal Tuberculosis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clarke, M. D.

5.17.1922 (Address) 1360 W. Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 18 1922
20 UNDERTAKER	ADDRESS
Edward Ringgold	1463 Carey

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 64399 — PLACE OF DEATH

5 | D 64399 — REGISTERED No. C

CITY OF BALTIMORE (No. 12 Church ave violetville ST. 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Darner

(Residence in Baltimore: No. 12 church ave St.: 12 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Aug. 27, 1858 (Month) (Day) (Year)

7-AGE: 63 yrs. 8 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Drug packer
(b) General nature of industry, business, or establishment in which employed (or employer): 0.86

9-BIRTHPLACE (State or country): Balto.

PARENTS

10-NAME OF FATHER: John Andrew Dorner

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Anna D. Baner

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lydia C. Dorner

(Address) 12 Church Ave Violetville

15-

Filed MAY 18 1922 GG REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apl 28, 1922 to May 16 1922 that I saw h~~im~~ alive on May 15, 1922 and that death occurred, on the date stated above, at 4 a, m.

The CAUSE OF DEATH* was as follows:

Uraemic Intoxication

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY) Arteriosclerosis.

(Duration) yrs. mos. 20 ds.

(Signed), Physician Dill M. D.

May 17, 1922 (Address) 1433 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: May 18, 1922

20-UNDERTAKER: George Schwab

ADDRESS: 710 Eutaw Ave

N. B.—Every item must be answered; state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of the facts are very important. See instructions on back of certificate.

(Kailer)

64400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64400

CERTIFICATE OF DEATH.

REGISTERED NO. 457

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Kailer

(a) RESIDENCE. NO. Owings Mills, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Albert Kailer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Matron - 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Stavers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

11 Informant Univ. Hospital records.
(Address)

15 MAY 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16-22 19

17 I HEREBY CERTIFY, That I attended deceased from 5-10, 1922, to 5-16, 1922, that I last saw her alive on 5-16-22, 19, and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

acidosis (Diabetic)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cystic left ovary -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5-12-22

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) H B Jones, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 19 19 22

20 UNDERTAKER A S Marshall ADDRESS 3539 Falls Rd

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64401

REGISTERED NO. M-001 M D 64401

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 652 N. Franklin ST., 17 WARD)

2-FULL NAME Mrs. Annie R. Farrell.

(a) RESIDENCE NO. 652 N. Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: Patrick H. Farrell.

6 DATE OF BIRTH (month, day, and year): Oct. 1-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Elizabeth McEvoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Miss Anne Farrell

(Address): 652 N. Franklin

15 Filed MAY 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to May 17, 1922, that I last saw h alive on May 11, 1922, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of May 16 1922

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) F. J. Rigney, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 20 1922

20 UNDERTAKER: Wendell Dippel & Son — ADDRESS: 378 N

CAUSE OF DEATH: See instructions on back of certificate. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for drainage of parotid gland. Prob primary?

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 64402

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL, (St.) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Thomas

(a) RESIDENCE. No. 1209 Arlington St., Ward. Govans, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	child.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child 00

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Lawrence Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed MAY 13 1922 19 Registrar

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to May 16, 1922, that I last saw her alive on May 16, 1922, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, cervical glands-
Tuberculosis, pulmonary

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of April 30, 1922.

Was there an autopsy? No.

What test confirmed diagnosis? Tuberculin Tests -

(Signed) Horace G. Stewart, M. D.

5/18, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 20 1922
20 UNDERTAKER Samuel Hemsley McCabe	ADDRESS 37

Spec.—6-9-19—H. P. Co.—1000 Bks.

Florence May Wright

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64403

CERTIFICATE OF DEATH.

74 D 64403

REGISTERED NO.

1-PLACE OF DEATH Florence May Wright

CITY OF BALTIMORE: No. Union Mem. Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Carl McLean~~ L. Wright (Florence)

(a) RESIDENCE. NO. 1205 Laurens St. ST., WARD. Baltimore.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. L. Wright.

6 DATE OF BIRTH (month, day, and year) May 9 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65		0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Edwin D. Phelps.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs L. Wright
(Address) 1205 Laurens St

15 Filed . 19 Registrar

MAY 1 8 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 17, 1922, that I last saw h.er alive on May 17, 1922, and that death occurred, on the date stated above, at 4:31 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

OVER

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 11 1922

Was there an autopsy? no

What test confirmed diagnosis? Clinical course

(Signed) OB Price, M. D.

, 19 (Address) Union Memorial Hospital Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery DATE OF BURIAL May 19 1922

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson ave

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

[REVISED] UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Slight stroke apoplexy which caused fall & slight fracture of tibia. Operation fal fracture. Second stroke while in hospital from which she never recovered. Pneumonia broncho. Primary apoplexy

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64404 (REGISTERED NO.)

D 64404
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2827 Clifton Ave, ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Armstrong Anderson

(a) RESIDENCE. NO. 2827 Clifton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed,~~ or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — Eliza Hill Anderson

6 DATE OF BIRTH (month, day, and year) 1864-12-4

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work asst Sec 086

(b) General nature of industry, business, or establishment in which employed (or employer) Graham Storage

(c) Name of employer Whse

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Eliza H. Anderson
(Address) 2827 Clifton ave.

15 MAY 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15 1922, to May 15 1922, that I last saw him alive on May 15 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
Acute attack - 1 hr.
(duration) ... yrs. ... mos.

CONTRIBUTORY (Secondary) Arterio-Sclerosis
(duration) 4-5 yrs. — mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) A F Robinson, M. D.
5/6 1922 (Address) 1307 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 5-18 1922

20 UNDERTAKER Henry A Jenkins Sons Co

ADDRESS McCulloh Orchard.

CAUSE OF DEATH. ... TION is very important. See instructions on back of certificate.

EALTH DEPARTMENT—CITY OF BALTIMORE

D 64406 90 D 64406

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEA Bessie Raison Cole

CITY OF BALTIMORE The Hopkins apts 34th & St. Paul Sts. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME ~~Elizabeth~~ Raisin Cole

(Residence in Baltimore: The Hopkins apts 34th & St Paul Sts Life St. yrs., mos. 7 ds.)

PERSONAL AND STATICAL PARTICULARS.

3 SEX

4-COLOR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17 Wednesday 1912

(Month) (Day) (Year)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64405

CERTIFICATE OF DEATH.

D 64405

REGISTERED NO. 40 D 64405

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 5 — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sewell Collins

(a) RESIDENCE NO. 512 N. High St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmers

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Chas. Collins'

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital.

15 MAY 18 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1922, to May 15, 1922, that I last saw him alive on May 14, 1922, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Urinary extravasation due to stricture of urethra —

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia & Sepsis —

unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5-14-22

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) F. H. Brumbeck, M. D.

5/15/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 19 1922

Commissioner of Health.

CAUSE OF DEATH must be stated. See instructions on back of certificate.

64

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64406

CERTIFICATE OF DEATH.

90 D 64406

REGISTERED No. C

1. PLACE OF DEATH Bessie Raison Cole

CITY OF BALTIMORE (No. the Hopkins apts 34th & St Paul Sts 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME. ~~Elizabeth~~ Rosin Cole

(Residence in Baltimore: No. the Hopkins apts 34th & St Paul Sts Life St. yrs.. mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, ~~WIDOWED~~, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1870 (Year)

7-AGE, about 52 years ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Robert N. J. Rosin

11-BIRTHPLACE OF FATHER (State or Country), Kent County,

12-MAIDEN NAME OF MOTHER Margaret A Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Cole

(Address) 40 E Chase St

15- Filed MAY 18 1922 191.. ROBERT R. KRAUTER, Burial Permit Registrar.

CAUSE OF DEATH. All parts should be filled in. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17th Wednesday 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

191.. (Address) 702 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Fellowcroft Cem

DATE OF BURIAL. May 19. 1922

20-UNDERTAKER J. H. Jenkins & Co

ADDRESS 1 Eutaw & Mc Culloh Sts.

PARENT

(State or Country) Kent County, [illegible]

12-MAIDEN NAME OF MOTHER Margaret A Johnson

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Cole

(Address) 40 S Charles St

15- Filed MAY 18 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cem — DATE OF BURIAL, May 19, 1922

20-UNDERTAKER H H Jenkins Sons Co — ADDRESS Eutaw & Lexington Sts

CAUSE OF DEATH in plain words. Every question must be answered. Information is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Rotimer 212 E Preston.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64407 — 3/Y D 64407

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 44 Hafer ST. 20 WARD)

2-FULL NAME Roland Gunn Wells

(a) RESIDENCE NO. 44 Hafer ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Balt - (State or country)

PARENTS

10 NAME OF FATHER Harry Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Knopf

13 BIRTHPLACE OF MOTHER (city or town) Balt - (State or country)

14 Informant Mrs Mary Dolch (Address) 44 Hafer St

15 Filed Robert P. Harrison, Registrar

8922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to May 16, 1922, that I last saw h[illegible] alive on May 16, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Catarrh

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Rotimer, M. D.

. 19 (Address) 212 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL May 19, 1922

20 UNDERTAKER Wm Cook — ADDRESS 417 E. N.O.

D 64408

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64408

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 327 S. Fremont ave ST. 22 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth H. Howard

(Residence in Baltimore: No. 327 S. Fremont ave St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, ~~Dec~~ July 13, 1847 (Month) (Day) (Year)

7-AGE, 74 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Annapolis Md

PARENTS.

10-NAME OF FATHER: John Anderson

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Sallerfield

13-BIRTHPLACE OF MOTHER (State or Country): Judid

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Howard

(Address) 327 S. Fremont ave

15-

Filed ..... 1922 Robert P. Harrison, Registrar.

Buried ..... Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

since Feb 1922 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

yrs. mos. ds.

(Signed) H K Fry M. D. (Coroner.)

5-18, 1922 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, May 20, 1922

20-UNDERTAKER William Cook — ADDRESS 542 E North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64409

CERTIFICATE OF DEATH.

146 D 64409

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Cheramie.

(Residence in Baltimore: No. 2340. Barclay St. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	M.

6-DATE OF BIRTH, Feb. (Month) 17 (Day), 1896 (Year)

7-AGE. 26 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John Schellenberger

11-BIRTHPLACE OF FATHER (State or Country). Dont Known

12-MAIDEN NAME OF MOTHER. Louisa Shappe

13-BIRTHPLACE OF MOTHER (State or Country). Dont Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earnest Cheramie

(Address) 2340 Barclay St.

15- Filed....., 191... Robert F. Harrison Registrar.

7.1 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 17 (Day), 1922 (Year)

I HEREBY CERTIFY, That I attended deceased from March 24 1922, to May 17 1922, that I saw h[illegible] alive on May 17 1922, and that death occurred, on the date stated above, at 6 9. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

....., 191... (Address) St Josephs Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. May 19, 1922

20-UNDERTAKER William Cook ADDRESS 502 E. North ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64410

D 64410

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caden A. Maxwell

(a) RESIDENCE. NO. Stedman N. C. ST., WARD. Stedman N. C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Leb. Stedman

6 DATE OF BIRTH (month, day, and year) Feb. 23-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Alexander Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Elizabeth Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed ..... 19 ..... Registrar

Robert T. Harrison, Jr.

MAY 18 1922

Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17- 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2- 1922, to May 17- 1922

that I last saw h~~im~~ alive on May 17- 1922,

and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Nephrolithiasis, right

(duration) 25 yrs. + mos. ds.

CONTRIBUTORY (Secondary) Nephrolithiasis & hydronephrosis, Left, with obstruction (duration) 23 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5.17.22

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) J. L. Houghton, M. D.

, 19 (Address) Johns Hopkins Hospital Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stedman N Ca

DATE OF BURIAL May 20 1922

20 UNDERTAKER Joseph Adams

ADDRESS 221 N Bro

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64411

100-001

D 64411

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Edward O. Brooks

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56.	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Balto, Md.

15 MAY 19 1922 ROBERT A. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 17, 1922

that I last saw him alive on May 17, 1922

and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) A. Goldsmith M. D.

5/17/22 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. Dotson Cemetery

DATE OF BURIAL May 20 1922

ADDRESS 142 W. Hill St

20 UNDERTAKER John H. Toadvine

CAUSE OF DEATH in plain terms. Abbreviations not allowed. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64412

CERTIFICATE OF DEATH.

46 D 64412

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 Belair ave 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Daffin

(a) RESIDENCE NO. 2304 Belair ave WARD 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Daffin

6 DATE OF BIRTH (month, day, and year) June 16 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER James H Spinks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Mary Spinks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Mary L Daffin

(Address) 2304 Belair ave

15 Date received MAY 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to May 16, 1922,

that I last saw h[illegible] alive on May 16, 1922,

and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Miller Hemming M. D.

5/7 1922 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL May 19 1922

20 UNDERTAKER Wendell Oppel & Son — ADDRESS 323 N

IMPORTANT—WRITE CAUSE OF DEATH in plain terms, so that it may be understood. See back of certificates. CAUSE OF DEATH is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64413

CERTIFICATE OF DEATH.

148

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St.; 0 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Rose

(Residence in Baltimore: No. 250 S. Exeter St.; 19 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 2, 1891. (Month) (Day) (Year)

7-AGE, 31 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 031

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Tony Pezza

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mariana Pizza

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Rose

(Address) 250 S. Exeter

15- Filed MAY 19 1922 191..... ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to May 18, 1922, that I saw her alive on May 18, 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza Epidemic

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. N. Farnum M. D.

....., 191... (Address) 2631 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincent — DATE OF BURIAL, May 2, 1922

20-UNDERTAKER Windell Rippel — ADDRESS 373 Mn

important. See instructions on back of certificate.

Spec.--8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64414

D 64414

CERTIFICATE OF DEATH.

155

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1060 Granby ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Kitterling

(Residence in Baltimore: No. 1060 Granby St.; (yrs. 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (~~Write~~ the word.) Married

6-DATE OF BIRTH, Jan 30, 1867 (Month) (Day) (Year)

7-AGE, 55 yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Do not Know

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Do not Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella C. Kitterling

(Address) 1060 Granby

15 MAY 1 1922 ROBERT R. KRAUTER,
Filed....., 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1922, to May 18th 1922, that I saw h in alive on May 17th 1922, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Abcess of antrum, right side

(Duration).....yrs.....mos.2.....ds.

CONTRIBUTORY (Secondary) Infection from tooth (Duration).....yrs.....mos.30.....ds.

(Signed) Chas. J. Keller M. D.

May 18th, 1922, (Address) 222 W. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity — DATE OF BURIAL, May 20, 1922

20-UNDERTAKER Wendell Dypert & Son — ADDRESS 37 S Ann St

Important. See instructions on back of certificate.

Junior B. Roberts

D 64415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64415

CERTIFICATE OF DEATH.

Registered No. C 14 100,001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1810 Eagle St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Junior B. Robert

(Residence in Baltimore: No. 1810 Eagle St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Single

6-DATE OF BIRTH. January 17 (Month) (Day) 1921 (Year)

7-AGE.	If LESS than 1 day.
1 yrs. 3 mns. 16 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Herbert Robert

11-BIRTHPLACE OF FATHER. (State or Country). Toronto Canada

12-MAIDEN NAME OF MOTHER. Emma Kendall

13-BIRTHPLACE OF MOTHER. (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Roberts

(Address) 1810 Eagle St

15- Filed MAY 1 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions Sudden

(Duration) yrs. mos. ds.

(Signed) James M. Preston M. D. (Coroner.)

May 18 1922 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	5/19 1922

20-UNDERTAKER. MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1535 W. PRATT STREET. ADDRESS

State CAUSE OF DEATH very carefully and in detail. See instructions on back of certificate. This is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

BOWERS

64416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64416

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 322 E. 28th St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Bowers

(a) RESIDENCE. NO. 322 E. 28th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Bowers.

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 816

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Samuel T. Bowers

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Lydia Crouse.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mrs. Marie Bowers

(Address) 322 E. 28th St.

15 MAY 19 1922 ROBERT R. KRAUTER, Registrar

Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 22 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13 22, 19, to May 17 22, 19,

that I last saw h alive on May 17 22, 19,

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

Chronic Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Edw. L. Coolahan, M. D.

5/18/22 (Address) 24 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 20 19 22
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1201 E Eager St

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Hynson

64417

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 - 001

74 D 64417

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1505 Jefferson St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P Hynson

(Residence in Baltimore: No. 1505 Jefferson St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 11, 1865
(Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Phelps Hynson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriet Chotts

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Hynson

(Address) 1505 Jefferson

15- FILED MAY 19 1922 ROBERT A. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)

5-18-22, 1922 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, May 21, 1922

20-UNDERTAKER Theodore Hirte

ADDRESS 119 Hoffman St

N. B.—Every item of information should be given so that it may be properly classified. Each CAUSE OF DEATH in plain terms, so that it may be properly classified. Each important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64418

CERTIFICATE OF DEATH.

90 D 64418

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 W. Saratoga ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie E. Cole-Murray

(a) RESIDENCE. No. 121 W. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of: Robert L. Murray

6 DATE OF BIRTH (month, day, and year): Aug 1-1889

7 AGE: Years 32 | Months 9 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework-home
(b) General nature of industry, business, or establishment in which employed (or employer): boarding-house
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto county Md

PARENTS

10 NAME OF FATHER: John W. Cole.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto county Md

12 MAIDEN NAME OF MOTHER: Mary McComas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md

14 Informant: William A Cole
(Address) 2880 Woodbrook Ave Cat

15 Filed 1 9 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28 . 1922, to May 18 . 1922, that I last saw her alive on May 18 . 1922, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Daniel Miller, M. D.

, 19 (Address) 1536 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: May 20 1922

20 UNDERTAKER: Butler & Lose

ADDRESS: 1723 N. Eden St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64419

CERTIFICATE OF DEATH.

49 D 64419

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Proimsel

(a) RESIDENCE NO. 1523 E. Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed MAY 19 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922 to May 18, 1922, that I last saw him alive on May 18, 1922, and that death occurred, on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH* was as follows:

Hypernephroma (left). Nephrectomy performed at Hebrew Hospital from where pt. was transferred

Metastasis (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY — (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At Hebrew Hospital.

Did an operation precede death? Yes Date of metastasis

Was there an autopsy? No — operative findings made at Hebrew Hospital

What test confirmed diagnosis?

(Signed) Lt. Brumbach, M. D.

5/19/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hamilton DATE OF BURIAL May 18 1922

UNDERTAKER William Cahn 502 E. Madison ADDRESS

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64420

HEALTH DEPARTMENT—CITY OF BALTIMORE

154 D 64420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME GARRETT DAVIS WATERS

(a) RESIDENCE. No. 1100-N-Charles-St. ST.. 11 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs ? mos. ? ds. How long in U. S., if of foreign birth? 60 yrs 9 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Latimer Waters

6 DATE OF BIRTH (month, day, and year) July-24-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Clerking. 069

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Watersville, Carroll Co., Md.

PARENTS

10 NAME OF FATHER Charles Richard Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Maryland.

12 MAIDEN NAME OF MOTHER Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co. Maryland.

14 Informant Dr. Charles A. Waters, (son)

(Address) 1100-N-Charles-St., City.

15 Filed MAY 19 1922 ROBERT A. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 17 1922. to May 19 1922.

that I last saw him alive on May 19 1922.

and that death occurred, on the date stated above, at 7:54 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gordon S. Seagrave M. D.

5-19, 1922 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Airy, Carroll Co., Md.	May-20-22

20 UNDERTAKER STEUART & MOWEN COMPANY (WILLIAM F. WOODS, Manager) ADDRESS 169 W. NORTH AVE.

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15596 Book C

D 64421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 64421

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Ellis

(a) RESIDENCE. No. 3438 Nyndenomin Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Feb 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Luke Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Alicia Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed MAY 19 1922 ROBERT R. KRAUTZ Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922 to May 17, 1922, that I last saw him alive on May 17, 1922 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (primary).

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Abscess of Lung; empyema

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) Horace G. Stewart, M. D.

May 19, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 19 22 19
20 UNDERTAKER	ADDRESS
R. S. Marshall	3539 Fallsway

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

64422

CERTIFICATE OF DEATH.

123 D 64422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2507 Foster Ave ST., 1 WARD)

2-FULL NAME Margaret Kelley

(a) RESIDENCE NO. 2507 Foster Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James R. Kelley

6 DATE OF BIRTH (month, day, and year): Jan 14, 1868

7 AGE — Years: 54 Months: 4 Days: 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: George Lindemann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): James R. Kelley 2507 Foster Ave

15 Filed MAY 19 1922 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be of certificates. See instructions on back TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 17, 1922.

that I last saw her alive on May 17, 1922

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 3/8/22

Was there an autopsy? no What confirmed diagnosis? Physical signs

(Signed) Chas. O. Neer, M. D.

5/14/22 (Address) 408 S Paca St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Evangelical Cem — DATE OF BURIAL: May 20 1922

20 UNDERTAKER: L. Sander Sons — ADDRESS: 1710 Eden St

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 64423

CERTIFICATE OF DEATH

164 D 64423

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1106 Hamburg St. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Fulton

(Residence in Baltimore: No. 1106 Hamburg St.: 50 yrs. — mos. — ds.)

N.B.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64424 ✓ 90 D 64424

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Lemmt ST.: 13 WARD)

2-FULL NAME Antonia Nasfalski or Tom Nasfalski

(a) RESIDENCE. NO. 706 Lemmt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal miner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia Poland

PARENTS

10 NAME OF FATHER Alexander Nasfalski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Nasfalski
(Address) 706 Lemmt St

15 Filed MAY 19 1922 Registrar

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17

I HEREBY CERTIFY, That I attended deceased from May 14 1922, to May 18 1922, that I last saw h[illegible] alive on May 14 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) [illegible], M. D.

May 19 1922 (Address) 24 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 20 1922
20 UNDERTAKER	ADDRESS
Israel Syfer	1605 W. North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 64425 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 64425

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 N. Fulton Avenue ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Snyder

(a) RESIDENCE NO. 1639 N. Fulton Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Snyder

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 53 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis

(Address): 1439 E. Balto St.

15 MAY 19 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19th 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to May 19, 1922, that I last saw h alive on May 18, 1922, and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency and Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morrison, M. D.

, 19 (Address) 1013 N. Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fulton Burying Pun. — DATE OF BURIAL: 5/19/22

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64426

D 64426

CERTIFICATE OF DEATH.

161

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Mc Henry St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Premature infant of Evelyn & Roland Brisco

(a) RESIDENCE. NO. 1610 Mc Henry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day 2½ hrs. or min.
	-	-	-	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Roland M Brisco

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Leesburg Va

12 MAIDEN NAME OF MOTHER Evelyn Mae Hidwell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Fairfax Va

14 Informant Roland Matt Brisco
(Address) 1610 N. Mc Henry St

15 MAY 19 1922 ROBERT R. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/22 19

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to 5/17/22. , 19.....,

that I last saw h... alive on 5/17/22 , 19.....,

and that death occurred, on the date stated above, at 1129 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Tests

(Signed) John Hauff, M. D.

, 19 (Address) 1843 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

TION is very important. See instructions on back of certificate.

1921A

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64427

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1,002

D 64427

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gersht

(a) RESIDENCE No. 1305 Cookrie St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44/10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Gersht

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamfore

(b) General nature of Industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER John Gersht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Hungary (State or country)

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 MAY 1 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 3, 19 22, to May 17th, 19 22,

that I last saw h alive on May 17th, 19 22,

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 12 1922

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

5/16, 19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 20 19 22

20 UNDERTAKER: H. B. Nusbaum — ADDRESS: 2336 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Cohn)

Spec.—1-19-21—M&T—1500 Bks.

D 64428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64428

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~E~~ 3203 Lemmon ST., 13 WARD)

2-FULL NAME Isador Cohn

(a) RESIDENCE NO. 3203 Lemmon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta Cohn

6 DATE OF BIRTH (month, day, and year): Sept 21st 1859

7 AGE: Years 62 Months 7 Days 27 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Dry Goods Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Simon Cohn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fredericka Cohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Cohn 3203 Lemmon Av

15 Robert, E. [illegible] Registrar

7 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922, to May 18, 1922, that I last saw h... alive on May 17, 1922, and that death occurred, on the date stated above, at 7.45A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray Exam.

(Signed) Theodore N. Morrison, M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: May 21 1922

20 UNDERTAKER: Harry Goudheim — ADDRESS: 118 W. Lexington

CAUSE OF DEATH in plain terms. Abbreviations not allowed. See instructions on back of certificates. TION is very important.

D 64429 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64429

CERTIFICATE OF DEATH.

Registered No. C. 9

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 W. Biddle St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Corine Harris

(Residence in Baltimore: No. 520 W. Biddle, St.; yrs., 5 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Nov. 21, 1916 (Month) (Day) (Year)

7-AGE: yrs. 5 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS:

10-NAME OF FATHER: Geny Harris

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Lizzie Holmes

13-BIRTHPLACE OF MOTHER, (State or Country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Harris

(Address) 520 W. Biddle St.

15- Robert P. Harrison, 192
Burial Permit Clerk
Registrar.

1 91922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Whooping cough

(Duration) yrs. mos. 14 ds.

(Signed) J. T. Hennessy M. D.
(Coroner)
May 18, 1922 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. May 19th 1922

20-UNDERTAKER. ADDRESS 527

Samuel H. Hendry & Bro.

is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

155904
D 64430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 64430

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL. ST.: (If death occurred in a hospital or institution, give its NAME instead of street and number.) WARD)

2-FULL NAME Labella Harris.

(a) RESIDENCE. NO. 520 W Biddle St. City. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Fred Harris (uncle).

6 DATE OF BIRTH (month, day, and year) Sept 2, 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 001

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Harris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lizzie Holmes.

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ....., 19.. Robert P. Harrison, Registrar

Burial Permit Clerk

MAY 19 1922

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14th, 1922, to May 18th, 1922, that I last saw h~~er~~ alive on May 18th, 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pertussis?

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No- Date of

Was there an autopsy? Yes-

What test confirmed diagnosis? Tuberculin - x - Ray -

(Signed) Horace G. Stewart, M. D.

May 18, 1922. (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 19th 1922

20 UNDERTAKER Samuel J. Hendry ADDRESS 57 W Biddle

Spec.—1-10-21—M&T—1500 Bks.

D 64431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64431

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 Falls Road ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hayward

(a) RESIDENCE NO. 225 Falls Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Hamilton Hayward

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Minnie Johnson (Address) 225 Falls Road

15 6-19-1922 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 18. 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1922, to May 18, 1922, that I last saw h-e alive on May 17, 1922, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Senile degeneration - Arterio Sclerosis - chron. Bronchitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C H Beetem, M. D.

6.18. 1922 (Address) [illegible] Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: May 20 1922

20 UNDERTAKER: Edmund T Bewley

ADDRESS: N Bdle

CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64432

CERTIFICATE OF DEATH.

D 64432

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bordley

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1821

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	101			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ofd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Conneticut.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MAY 19 1922

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 24 . 1921 . to May 17 . 1922 .

that I last saw him alive on May 16 . 1922 .

and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

5/19 19 22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 20 '22

20 UNDERTAKER: Daniel J. Hendley ADDRESS: 2538 Eden

Spec.—1-10-21—M&T—1500 Bks.

D 64433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64433

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1845 Presstman ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah Elizabeth Poist

(a) RESIDENCE NO. 1845 Presstman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Poist

6 DATE OF BIRTH (month, day, and year) August 13th, 1871

7 AGE: Years 50 | Months 9 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Samuel F. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Georgianna Free

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Charles Milton Poist
(Address) 1845 Presstman St

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to May 18, 1922, that I last saw her alive on May 17, 1922, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Physical

(Signed) Edw C. Goodwin M. D.

5/19/22 (Address) 347 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: May 22nd, 19 22

20 UNDERTAKER: Bertram L Gore — ADDRESS 1723 W Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

16 c Black

1 9 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64434

CERTIFICATE OF DEATH.

90 D 64434

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2132 E. Federal St.; 9 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie C Jockisch

(Residence in Baltimore: No. 2132 E. Federal St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, October 17 (Month) 1857 (Day), 1 (Year)

7-AGE, 62 yrs. 7 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, August Gassinger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Landbrig

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Arthur Jockisch

(Address) 2123 E Federal St

15- Robert P. Harrison, ..., 191.....
Burial Permit Clerk. Registrar.

NB. Every item of information must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation very important. See instructions on back of certificate.

1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 18 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner.)

5-19-22, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery | DATE OF BURIAL, May 22, 1922

20-UNDERTAKER Henry Hoeck Son | ADDRESS 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64435

D 64435

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St. Agnes Hospital St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Stafford

(a) RESIDENCE NO. St Mary's Industrial School ST., WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE W. White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Married

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) St Mary's Industrial School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not Know

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not Know

14 Informant Brother Michael Stafford

(Address) St. Mary's Industrial School

15 Dec 1922, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-19 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-6-, 1922, to 5-19, 1922, that I last saw him alive on 5-19, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Sotaemia from Perforation of Intestine Cause.

24 hrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma - Cardias end of Stomach ? ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/18/22

Was there an autopsy? Yes 5/19/22

What test confirmed diagnosis? Autopsy.

(Signed) H V Harper M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 5/20 1922

20 UNDERTAKER Thos F Toale & Son — ADDRESS 1100 Mt Royal Ave

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64436

CERTIFICATE OF DEATH.

D 64436

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 W. North Ave ST.: 13 WARD)

2-FULL NAME Augusta A. McGreevey

(a) RESIDENCE. NO. 704 W. North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. H. McGreevey

6 DATE OF BIRTH (month, day, and year) Unknown 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Curtis Carlan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lucinda Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Francis McGreevey (Address) 704 W. North Ave

15 [illegible] 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MAY 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15 1922, to May 18 1922, that I last saw h[illegible] alive on May 18 1922, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. — mos. — ds. —

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Violent pain in head followed by unconsciousness & death

(Signed) Charles O'Donovan, M. D.

May 19 1922 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/22/22

UNDERTAKER Chas. F. Evans & Son ADDRESS 118 W. Mt. Royal Ave

CAUSE OF DEATH. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64437

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4848 Park Heights St. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Purcell

(a) RESIDENCE. No. 4848 Park Heights Av. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~(HUSBAND)~~ of (or) WIFE of: Charles T. Purcell

6 DATE OF BIRTH (month, day, and year): June 9 1894

7 AGE — Years: 27 Months: 11 Days: 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frank D. Gildea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Minnie M. Burg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Frank D. Gildea

(Address): 4848 Park Heights Av

15 Filed ..., 19 ... Registrar

Robert P. Harris, Special Permit Clerk.

1922

CAUSE OF DEATH in plain terms, so that a ... may understand it. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from June ..., 19 22, to May 18, 19 22, that I last saw h[illegible] alive on May 18, 19 22, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Bubert M. D

May 9, 1922 (Address) 4834 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: MAY 22 1922, 19

20 UNDERTAKER: Geo W Little

ADDRESS 3700 Edmondson Av

Spec.—1-10-21—M&T—1500 Bks.

D 64438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64438

CERTIFICATE OF DEATH.

REGISTERED NO. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2508 Mosher St. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella D. Byrd

(a) RESIDENCE NO. 2508 Mosher St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Levin J. Byrd

6 DATE OF BIRTH (month, day, and year) May 24th 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John E. Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sally A. Trehearn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Levin J. Byrd

(Address) 2508 Mosher St.

15 Filed 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 20 1921 to May 18 1922.

that I last saw her alive on May 18 1922

and that death occurred, on the date stated above, at 4.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Colin Munro M. D.

May 19th 1922 (Address) 1271 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkesley Va DATE OF BURIAL May 21st 1922

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 64439

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64439

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ..... ST., 60 WARD)

2-FULL NAME Emma Heckman

(a) RESIDENCE No. Williamson Pa ST., ... WARD Williamson Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Williamson Pa.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Heckman

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Keiper

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Amos Heckman
(Address) Williamson Pa

15 Robert P. Harrison, 19 .....
Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from May 15 19xx to May 19 19xx.

that I last saw h alive on May 19, 19xx.

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted (?
if not at place of death?

Did an operation precede death? Yes Date of May 6 19xx

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Eugene Barnett M. D.

, 19 (Address) Church Home Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greencastle Pa.	May 14 1922
20 UNDERTAKER	ADDRESS
H E Hughes	1st St Bdy

2 01922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64440

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: (WARD)

2-FULL NAME Kasmira Paskowski

(a) RESIDENCE. NO. 602 Baldwin St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) May 9-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Theophile Paskowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anastasia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAY 20 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19- 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5 - 1922, to May 19, 1922

that I last saw her alive on May 19 - 1922

and that death occurred, on the date stated above, at 6.20 P.m.

The CAUSE OF DEATH* was as follows:

Meningitis - meningococcus

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture + culture.

(Signed) Horace G. Stewart, M. D.

5/19, 1922 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	5/21 1922
20 UNDERTAKER	ADDRESS
Winand & Hudson	2 E Lexington

CAUSE OF DEATH to be given by physician. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64441

CERTIFICATE OF DEATH.

129 VD 64441

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 147 N. Montgomery ST. 22 WARD)

2-FULL NAME Moses F. Johnson

(a) RESIDENCE. NO. 147 N. Montgomery ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Widowed

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Eliza Verges

6 DATE OF BIRTH (month, day, and year) June 11 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 868

(b) General nature of industry, business, or establishment in which employed (or employer) Business College

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Farmville Va.

PARENTS

10 NAME OF FATHER Albert? Johnson not certain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Mrs. Mattie Caldwell (Address) 5 E. Lee St.

15 Filed 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17 1922

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to May 16, 1922, that I last saw him alive on May 16, 1922, and that death occurred, on the date stated above, at 6:25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis and Mitral Insufficiency.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	May 21 1922
20 UNDERTAKER	ADDRESS
J. H. Brown & Son	10 E. Monty St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 64442

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Sinai Hosp St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sara Jane Kane

(a) RESIDENCE. No. 718 E 41 St St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 22 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm Mates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Coyles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Son

15 Filed May 19 1922 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/17 1922 to 5/18 1922,
that I last saw h alive on 5/18/22, and that death occurred, on the date stated above, at 8 30 a m

The CAUSE OF DEATH* was as follows:

Intra Pneumonic pleurisy
Diabetes Chronic Nephritis Myocarditis
Hypertension Senile Cardiac Changes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac dis

(duration) yrs. mos. ds.

18 Where was disease contracted ?
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical findings

(Signed) A Tompkins, M. D.

, 19 (Address) Mt Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 27 1922
20 UNDERTAKER Geo Rosset	ADDRESS 1442 N Gay

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64443

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1526 Riggs Ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucille Virginia Burroughs

(a) RESIDENCE. NO. 1526 Riggs Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 18 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 30 min.
	—	—	—	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Langdon Burroughs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Md.

14 Informant (Address) Langdon Burroughs 1526 Riggs Av.

15 Filed May 19 1922 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18 - 1922, to May 18 1922, that I last saw h[illegible] alive on May 18 1922, and that death occurred, on the date stated above, at about 9 a. m.

The CAUSE OF DEATH* was as follows:

Ped. Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. McC. Lockard, M. D.

5-18-22 (Address) 906 N. Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 20 1922
20 UNDERTAKER	ADDRESS
Sam'l N. Chase & Son	1400 Pitcher

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

I delivered one born half hour or more before my arrival. Mother stated baby born dead, but did not cry as baby was dead when I arrived, and cord was quite tight around neck. Placenta not delivered when I arrived.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64444

CERTIFICATE OF DEATH.

D 64444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 5322 Denmore ave ST.: 27 WARD)

2-FULL NAME Edith May Dorsey

(a) RESIDENCE. NO. 5322 Denmore ST., WARD. 27

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo F Dorsey

6 DATE OF BIRTH (month, day, and year) Nov. 11th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick (State or country) Md

PARENTS

10 NAME OF FATHER Harry P Cecil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katie Crabbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Husband. (Address) 5322 Denmore ave

15 Filed 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to May 18, 1922, that I last saw h[illegible] alive on May 18, 1922, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) 1 yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Goitre (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Charles J Wells, M. D.

, 19 (Address) 2 W Belvedere ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville, Md	May 21st 1922
20 UNDERTAKER	ADDRESS
James R Weer	Sykesville Md

CAUTION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64445

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 N. Charles St. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Lear Johnson

(a) RESIDENCE NO. 1015 N. Charles St. ST., ...WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas W. Johnson

6 DATE OF BIRTH (month, day, and year) Dec 29.1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	82	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Robert Earl

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Armitage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant (Address) Thomas J. Johnson 1015 N.Charles St.N.

15 ...1922 ..., 19... Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19.1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 29 .1922. to May 18 .1922.

that I last saw her alive on May 18 .1922.

and that death occurred, on the date stated above, at 1.45 A.M. p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

over 5 yrs - mos - ds.

(duration)

CONTRIBUTORY (Secondary) Acute Bronchitis -

(duration) - yrs. - mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Heller's test

(Signed) I. H. Mayo, M. D.

5/19, 1922 (Address) Baltimore, Md

Latodo apacto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 20 1922

20 UNDERTAKER John O. Mitchell

ADDRESS 1201 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64446

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 8 W. Hamilton St. ST., 11 WARD)

(If death occurred in a hospital or institution, give NAME instead of street and number.)

2-FULL NAME Laura Eleanora Keene

(a) RESIDENCE NO. 8 W. Hamilton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 6.1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co? Md.

PARENTS

10 NAME OF FATHER John Henry Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie D. Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) W. Pinkney Craig Earl Court Aparts.

15 1922 . 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 18. 1922

17 I HEREBY CERTIFY, That I attended deceased from APRIL 8th, 1922, to MAY 18th, 1922, that I last saw HER alive on MAY 17th, 1922, and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

DIABETES MELLITUS

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

MAY 19th, 1922 (Address) 905 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemy DATE OF BURIAL May 20 1922

20 UNDERTAKER John Ouitchell ADDRESS 1601 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact address TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 64447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64447

CERTIFICATE OF DEATH.

14

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 N. Washington ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Racie M. Tapfer

(a) RESIDENCE NO. 823 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Tapfer

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	8	27	

8 OCCUPATION OF DECEASED At home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adolph A. Tapfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret M. Stober

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Tapfer (Address) 823 N. Washington

15 1922 ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19th 1922, 19..., to May 20th 1922, 19...

that I last saw h[illegible] alive on May 20th, 19 22.

and that death occurred, on the date stated above, at 4.40 a m.

The CAUSE OF DEATH* was as follows:

Puerperal State

(duration) yrs. 2 hours mos. ds.

CONTRIBUTORY (Secondary) Pock Pattern Adenocarcinoma

(duration) yrs. mos. 2 months

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

May 20 19 22 (Address) 1201 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL May 24 1922

20 UNDERTAKER Zurhellen & Zurhellen — ADDRESS Eager 739

mation should be given in this column, so that it may be properly classified. Fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Robert P. Harrison, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64448

D 64448

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., N WARD)

2-FULL NAME Lena Mildred Ferguson

(a) RESIDENCE (No. 3925 Fait Av ST., WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 12 1911

7 AGE: Years 11 Months 1 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Thomas Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lena Heath

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mercy Hospital Records

15 Filed May 23 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1922

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 19, 1922,

that I last saw her alive on May 19, 1922,

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Symptoms

(Signed) John F. Ehrt, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn — DATE OF BURIAL: May 23 1922

20 UNDERTAKER: Funkler & Funkler — ADDRESS 1739 Eager

BURIAL PERMIT MUST BE SIGNED BY PHYSICIAN OR CORONER. CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF DEATH must be stated. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Permission is hereby granted to extend time of burial to May 24, 1922. Frederick Stempel Health Officer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64449

CERTIFICATE OF DEATH.

D 64449 REGISTERED NO. 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 S. Clinton ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Wischer

(a) RESIDENCE NO. 1002 S. Clinton ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. J. Wischer

6 DATE OF BIRTH (month, day, and year): June 16-1881

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ....mln.
40	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael J. Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Martha Faul

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: George J. Wischer (Address): 1002 S. Clinton St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1922 to May 19, 1922.

that I last saw her alive on May 16, 1922.

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pernicious Anemia (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood test

(Signed) Maxwell L. Mayer M.D.

5/19 1922 (Address) 3115 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 23 1922

20 UNDERTAKER: Kirkley & Kirkley — ADDRESS: 1739 Eager

Robert P. Harrison, Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT SPELLING. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64450

74-09 64450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3018 E. Pratt ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda C. Hertel

(a) RESIDENCE NO. 3018 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John G. Hertel

6 DATE OF BIRTH (month, day, and year): Nov 29 1862

7 AGE — Years: 59 — Months: 5 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Westminster Maryland

PARENTS

10 NAME OF FATHER: Conrad Pfeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIKTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Harry Hertel

(Address): 3018 E. Pratt St.

15 Filed ..... 19 ..... Registrar

1922 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922 to May 19, 1922

that I last saw her alive on May 18, 1922

and that death occurred, on the date stated above, at 3 35 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank Bowles, M. D.

May 19/22 (Address) 175 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL: May 22 1922

20 UNDERTAKER: A. Sunder & Sons — ADDRESS: 1710 Flat St.

mation should be entered, supplied, etc. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64451

CERTIFICATE OF DEATH.

44 D 64451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2533 W Lexington ST., 20 WARD)

2-FULL NAME Mary Margaret Eckert.

(a) RESIDENCE NO. 2533 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Henry Eckert.

6 DATE OF BIRTH (month, day, and year) May 25th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Frederick Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Waag.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss Emma Mueller (Address) 1212 N. Caroline St.

15 Filed Feb. 1 19 22 Robt. F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-19th 1922

17 I HEREBY CERTIFY, That I attended deceased from February 12 1922 to May 19th 1922, that I last saw her alive on May 17th 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Amelia E. Link M. D.

5/19, 1922 (Address) 1712 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 22 1922

20 UNDERTAKER Wm Cook

ADDRESS 47 E Mt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Y 2 01922 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64452

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Arbutus ave Lakeland ST. 75 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rach.

(a) RESIDENCE. NO. Arbutus ave Lakeland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan. 12th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Fred Rach.

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Marie Krenger

13 BIRTHPLACE OF MOTHER (city or town) Germany.
(State or country)

14 Informant (Address) John Lakeland

MAY 20 1922

, 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922 to May 18, 1922.

that I last saw her alive on May 18, 1922.

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Rigdon, M. D.

May 18. 1922 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 20 1922

20 UNDERTAKER Margaret E. Flynn

ADDRESS E. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

D 64453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64453

148

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Municipal Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Carrie Dixon

(Residence in Baltimore: No. 816 W. Ostend St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ..., 1902
(Month) (Day) (Year)

7-AGE, 19 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Westport, Md.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). St.Dennis, Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). St.Dennis, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records.

(Address) Municipal Hospital.

15- MAY 20 1922 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerpheral Tetanus

Unknown
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Spontaneous abortion

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Thos. D. Horton M. D.
(Coroner)

May 16, 1922 (Address) Curtis Bay, Balto Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, May 20 1922

20-UNDERTAKER David Earlon ADDRESS 516 Pa ave

Every item of information known to the undersigned should be given. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21 M&T 1500 Blks.

D 64454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D 64454

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 E. Fayette ST., 5 WARD)

2-FULL NAME Jacob H Schwartz

(a) RESIDENCE (Usual place of abode) No. 1315 E Fayette ST., WARD

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Schwartz

6 DATE OF BIRTH (month, day, and year) Sept 17th 1839

7 AGE — Years: 82 | Months: 9 | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe-maker (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

088

9 BIRTHPLACE (city or town) Lancaster (State or country) Pa.

PARENTS

10 NAME OF FATHER John Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Miss Emma Schwartz (Address) 1315 E Fayette St

15 MAY 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 18, 1922, that I last saw h— alive on May 18 1922 and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Stone Tumor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wilson, M. D.

May 19 1922 (Address) 22 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 5/20/1922

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: 1938 E. Lafayette Ave

A. B. C. mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64455

REGISTERED NO. 51 D 64455

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3113 Barclay ST., 17 WARD)

2-FULL NAME James B. Bailey

(a) RESIDENCE NO. 3113 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer G. M. C. A.

9 BIRTHPLACE (city or town) Albemarle County (State or country) Va.

PARENTS

10 NAME OF FATHER Susan C. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Effie Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Effie Bailey
(Address) 3113 Barclay at

15 Filed ....., 19.... Registrar

Robert F. Harrison, Burial Permit Clerk.

Y 20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1922

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1922, to May 17, 1922, that I last saw him alive on May 17, 1922, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Contributory

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Patient

(Signed) R. Randal Schmidt M. D.

May 20 1922 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL May 21 1922

20 UNDERTAKER Mrs. R. L. Elliott — ADDRESS 1720 Pennsylvania Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64456

CERTIFICATE OF DEATH.

70

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Gittinger Ave ST., Washington Park 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie J. Schmich

(a) RESIDENCE NO. 1231 Gittinger ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 1917

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
4	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER John A. Schmich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Rosa Berenger

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14 Informant John A Schmich

(Address) 1231 Gittinger Ave

15 Registrar Robert P. Harrison,

MAY 20 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 18, 1922, that I last saw her alive on May 18, 1922, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter Klopp, M. D.

, 19 (Address) 543 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. Co. DATE OF BURIAL: May 20 1922

20 UNDERTAKER: Margaret F. Flynn ADDRESS: 1427 Light St

A. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. If less than one year or one day, the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso i

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healtbfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not epidemic. No cerebro spinal complications. Simply a brain fever

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64457

CERTIFICATE OF DEATH.

100-001

D 64457

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4703 Reisterstown Rd ST.) 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eunice C. Pehley

(a) RESIDENCE NO. 4703 Reisterstown Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 13. 1919

7 AGE: Years 2 Months 11 Days 5 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ——

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John T. Pehley Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lula D. Browning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co Md

14 Informant (Address): Mr John T. Pehley 4703 Reisterstown Rd

15 Filed MAY 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 18, 1922, that I last saw her alive on May 18, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Child also had bronchopneumonia about

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. Herbert Brackbill, M. D.

, 19 (Address) Belvedere Ave 126

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: May 22 1922

20 UNDERTAKER: Jos Jacobs & Son

ADDRESS: 217 S Pac

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute nephritis following
broncho pneumonia.
No infection or abnormal
conditions prior.

D 64458

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64458

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1543 N. Gilmor St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Sheffield

(Residence in Baltimore: No. 1543 N. Gilmor St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH, ~~Nov~~ March (Month) ..., 1858 (Day) (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): 869

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Bannon

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Tangey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie McAllister

(Address) 1543 N. Gilmor St.

15-

Filed Robert P. Harrison, 191

Registrar.

2 01922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ~~in-~~ (Inquest, autopsy or inquiry.) Jury find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

May 20, 1922 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, St. Louis Cem. | DATE OF BURIAL, May 22 19 22

20-UNDERTAKER Harford Lakeside Co. | ADDRESS 1217 W North

N.B.—Every item of information should be carefully supplied. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64459

CERTIFICATE OF DEATH.

D 64459

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Rooney

(a) RESIDENCE. No. 316 N. Green st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not given

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Photographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

086

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James F. Rooney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Velleley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Hospital Records M.T.H.

15 Filed 1922 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1922, to May 17, 1922, that I last saw him alive on May 17, 1922, and that death occurred, on the date stated above, at 12:05 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalrymple M. D.

5-17 1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: MAY 20 1922

20 UNDERTAKER

ADDRESS

Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of pecu... TION is very important. See instructions on back of certificates.

MAY 20 1922

Spec.—1-10-21—M&T—1500 Bks.

D 64460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64460

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Simpson

(a) RESIDENCE No. 1333 Carroll St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Sanford Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Caroline

14 Informant (Address) Hospital Records, Municipal Hospital

15 Filed MAY 20 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 19 22

17

I HEREBY CERTIFY, That I attended deceased from March 30, 19 22, to May 16, 19 22,

that I last saw h er alive on May 15, 19 22,

and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Reed M. D.

5/18/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL MAY 20 1922

20 UNDERTAKER Commissioner Health,

ADDRESS

MAY 20 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64461

CERTIFICATE OF DEATH.

122-002

D 64461

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Norton

(a) RESIDENCE NO. Lee St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Jerry Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed 1922 Robert P. Harrison, Registrar

Burial Permit clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 15, 19 22 to May 15, 19 22, that I last saw him alive on May 15, 19 22, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Atrophic cirrhosis

2 years (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Marvel, M. D.

5/18/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Chas. H. Smith.

ADDRESS MAY 20 1922

mation should be entered, supplied, etc., so that it may be properly classified. Exact statement of occup
CAUSE OF DEATH in plain terms,
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64462

CERTIFICATE OF DEATH.

90 D 64462

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucius Davis

(a) RESIDENCE NO. 1307 Jefferson St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER: William Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MAY 20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 16, 1922, that I last saw him alive on May 15, 1922, and that death occurred, on the date stated above, at 7:25 A.M.

The CAUSE OF DEATH* was as follows:

Chronic bacterial endocarditis,

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 1 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Reed, M. D.

5/18/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Other Health,

ADDRESS

MAY 20 1922

mation should be carefully supplied. Note that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64463

CERTIFICATE OF DEATH.

D 64463

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Day

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Robert P. Harrison Registrar

MAY 20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1922

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 16, 1922, that I last saw her alive on May 16, 1922, and that death occurred, on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. O'Neill M. D.

5/18/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 20 1922

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 64464 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64464

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

City of BALTIMORE: (No. 138 N. Preston St., 11 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jannetta Keeny

(Residence in Baltimore: No. 138 N. Preston St.; yrs. 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	single

6-DATE OF BIRTH. Feb. 19, 1921 (Month) (Day) (Year)

7-AGE. 1 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (Infant)

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Benj. L. Keeny

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Josephine Henry

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benj. L. Keeny

(Address) 138 N. Preston St.

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

2 0 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) no history of contagious or infectious

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D. (Coroner)

May 19 1922 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Int. Auburn Cem. DATE OF BURIAL. 5/21 1922

20-UNDERTAKER. Jas. H. Skinner ADDRESS 1620 E. Mad. st.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64465

CERTIFICATE OF DEATH.

D 64465

1-PLACE OF DEATH 1514 Druid Hill ave

REGISTERED NO. 14 129

CITY OF BALTIMORE: (No. ..... ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Affer Custis

(a) RESIDENCE. No. 1614 Druid Hill Ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) Preacher.

(c) Name of employer .....

9 BIRTHPLACE (city or town) Northampton Co
(State or country) Virginia

PARENTS

10 NAME OF FATHER Isaac Custis

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Isabella Mapp.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Kitty Mapp
(Address) 1514 Druid Hill Ave

15 MAY 20 1922, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27th, 1922, to May 19th, 1922, that I last saw h[illegible] alive on May 8th, 1922, and that death occurred, on the date stated above, at 11-42 A, m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ..... yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Chronic Pneumonitis

(duration) One yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No incl findings

What test confirmed diagnosis? Urinalysis & Clin

(Signed) J. Bunnell Flagg, M. D.

, 19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Auburn Cem	5-22 1922
20 UNDERTAKER George H. Holland	ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64466

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Robert ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth N. E. Goodin

(a) RESIDENCE NO. 520 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of: John W. Gooden

6 DATE OF BIRTH (month, day, and year): Sep. 27, 1872

7 AGE — Years: 49 — Months: 7 — Days: 21 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Edmund Copeland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): California

14 Informant: John W Gooden

(Address): 520 Robert St

15 MAY 20 1922, 19 ... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/18/ 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12 1922 to May 18, 1922.

that I last saw her alive on May 18, 1922,

and that death occurred, on the date stated above, at 11 30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Valvulitis

(duration) Months mos ds.

CONTRIBUTORY (Secondary)

(duration) ~~yrs.~~ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Howard, M. D.

5/20/ 1922 (Address) 1121 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: May 21 1922

20 UNDERTAKER: Scott Holland — ADDRESS: 1631 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64467

CERTIFICATE OF DEATH.

90 D 64467

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Apts. Charles & 31st. St. St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac W. Mohler, Jr.

(a) RESIDENCE. No. Charles & 31st. St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Elzey

6 DATE OF BIRTH (month, day, and year) June 27, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cuyler & Mohler

(b) General nature of industry, business, or establishment in which employed (or employer): Plumbing Supplies

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac W. Mohler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Larsh

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant (Address): Mrs. Ella E. Mohler, Charles & 31st. Sts.

15 Filed ..... 19 ... Robert P. Garrison, Registrar

Y 2 01922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922.

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to May 19, 1922, that I last saw h alive on May 19, 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart & valvular heart disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. Wm. Deegen, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	5/22. 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

INFORMATION SHOULD BE GIVEN by someone acquainted with the facts. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

64468 . HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64468

CERTIFICATE OF DEATH.

REGISTERED NO. D 64468

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rock Island Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Otterbein

(a) RESIDENCE. No. St. George Lane Ten Hills St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Otterbein

6 DATE OF BIRTH (month, day, and year) June 13 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Simons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Schroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rev L. Otterbein
(Address) 31 N. Eutaw

15 MAY 21 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to May 19, 1922, that I last saw her alive on May 19, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? - - -

Did an operation precede death? No Date of - - -

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Edw. V. Coolahan, M. D.

5/, 19 22 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem A.C.	5/22 22
20 UNDERTAKER	ADDRESS
Farrelly Bro. C.	1801 N. Fayette

mation should be carefully supplied. Age should be stated in years. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

64469 D 64469

HEALTH DEPARTMENT—CITY OF BALTIMORE

64469 D 64469

CERTIFICATE OF DEATH.

129

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Aloysius Mc Donough

(Residence in Baltimore: No. 1317 Fayette St. St.; 1 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, June (Month) 4 (Day), 1873 (Year)

7-AGE, 48 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Smaker
(b) General nature of industry, business, or establishment in which employed (or employer): D.S.C.

9-BIRTHPLACE, (State or Country), Maine

PARENTS.

10-NAME OF FATHER, John A. McDonough

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary E. Dolan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary McDonough

(Address) 1317 W. Fayette St.

15- Filed MAY 21 1922, 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16 1922, to May 19 1922, that I saw him alive on May 19 1922, and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) J. E. Massey M. D.

May 19, 1922 (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Baltimore

Former or usual residence Portland, Maine.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Portland Me	5/20, 1922
20-UNDERTAKER	**ADDRESS**
Geo A Talley Sulton	Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64470 ✓

64470
D 64470

CERTIFICATE OF DEATH.

REGISTERED NO. C 117 D 64470

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N. Parrish Street ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Davis

(Residence in Baltimore: No. 513 N. Parrish St. St.; unknown yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Negro	Married

6-DATE OF BIRTH, May 17th. 1880 (Month) (Day), 1 (Year)

7-AGE, 35 yrs. 0 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress 041
(b) General nature of industry, business, or estsblishment in which employed (or employer): Worked at Home

9-BIRTHPLACE, (State or Country), West River Md.

PARENTS.

10-NAME OF FATHER, John Brown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Elizabeth Brown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A. Davis

(Address) 513 N. Parrish St.

15- Filed MAY 21 1922, 191... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18th. 1922 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Maylst 1922, to May 18th '22 191, that I saw h er alive on May 18th. '22 191, and that death occurred, on the date stated above, at 145 a.m.

The CAUSE OF DEATH* was as follows:

Acct. Peritonitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acct. Appendicitis

(Duration) yrs. mos. 18 ds.

(Signed) Walter J. Jackson M. D.

5/19/, 1922 (Address) 1618 W. Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 5/21/22, 191...

20-UNDERTAKER Sam'l B Chase Son — ADDRESS 1100 Mosher

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64471

CERTIFICATE OF DEATH.

8 117 D 64471

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine O'Neill Hedemann.

(Residence in Baltimore: No. 1601 E Lafayette St.; 45 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 15 (Month), 1865 (Day), (Year)

7-AGE, 56 yrs. 8 mos. 5 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Reddington

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Elizabeth Devine

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Reddington

(Address) 1601 E. Lafayette Ave

15- Filed MAY 21 1922, 191.... ROBERT J. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 1922, to May 20 1922, that I saw h[illegible] alive on May 20 1922, and that death occurred, on the date stated above, at 2 30 a. m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus and
Suppurative meningitis

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Gangrenous Appendicitis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Harold C. Pillsbury M. D.

May 20, 1922. (Address) 415 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, May 23, 1922

20-UNDERTAKER H. C. Middefeld — ADDRESS 914 Greenmt Ave

IN CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64472

CERTIFICATE OF DEATH.

91-007 D 64472

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Paul.

(a) RESIDENCE. No. Preston & Valley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anton Paul.

6 DATE OF BIRTH (month, day, and year): Jan 25 1832

7 AGE: Years 90 Months Days If LESS than 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Xavier Geilfuss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Agnes Beck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sister Florence.

(Address): Preston & Valley Sts.

15 Filed MAY 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...

that I last saw h[illegible] alive on May 18, 1922,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

May 19, 1922 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Josephs Belair Rd — DATE OF BURIAL: May 22 1922

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmount Av

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64473

CERTIFICATE OF DEATH.

118-D 64473

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Ensor ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Sinnott

(a) RESIDENCE. NO. 923 Ensor ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laurence Sinnott

6 DATE OF BIRTH (month, day, and year) Aug 15 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Mathew Guerin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt. Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Laurence Sinnott

(Address) 923 Ensor St.

15 Filed MAY 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18 1922 to May 19th 1922

that I last saw her alive on May 19th 1922

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) J. H. C. Baker, M. D.

May 20 1922 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 22 1922

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64474

CERTIFICATE OF DEATH.

X | MD 64474

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David S. Walton

(a) RESIDENCE. No. Washington, D.C. 815 6th St. N.E. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Catherine A. Walton

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER John R. Walton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Ellen Kemble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 MAY 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from ~~May~~ 28, 1922, to May 20, 1922, that I last saw him alive on May 20, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Nephritis, Hydronephrosis

2 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, Acute pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Washington, D.C.

Did an operation precede death? Yes Date of 5-5-22

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Franklin P. Johnson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL 5/21 1922

20 UNDERTAKER Philip Herring ADDRESS 2016 Adam

mation should be carefully supplied. All items should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 64475

D-64475

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 N Eden St. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma D Wolle

(a) RESIDENCE No. 1209 N Eden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of: Wm J Wolle

6 DATE OF BIRTH (month, day, and year): April 23 1852

7 AGE: Years 69 | Months | Days 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George M Groskopff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Justine Sifferin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas L Wolle
(Address) 1209 N Eden Street

15 MAY 21 1922 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk~~

Kraft 1216 E Preston St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1921, to May 20, 1922, that I last saw her alive on May 20, 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert A Knapp, M. D.

May 20, 1922 (Address) 1216 E. Preston

(over)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. | DATE OF BURIAL: May 22 22

20 UNDERTAKER: Wm J Wolle & Sons | ADDRESS: 502 E North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. If less than one year, state months, days or hours. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Rzepakeski

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

D 64476

D 64476

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 Jo Hospital St.: 1 WARD)

(If death occurred in a hospital or institution give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME John Rzepakeski

(Residence in Baltimore: No. 1521 E. Chase St.) 4 yrs., mos. ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1847 (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Barber
(b) General nature of industry, business, or establishment in which employed (or employer) Own business

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Rzepakeski

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Rzepakeski

(Address) 1521 E Chase

15-

FILED MAY 21 1922 ROBERT R. KRAUTER,

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 18 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by hands of parties unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. Krauter Jr. M. D. (Coroner.)

5-18-, 1922 (Address) 4 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, May 22, 1922

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64477

D 64477

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234-5th St. ST., W. WARD)

2-FULL NAME Helen A Yaeger

(a) RESIDENCE NO. 234-5th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY with pen and ink. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	27	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER G Fredrick Yaeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant G Fredrick Yaeger

(Address) 234 5th St.

15 Filed MAY 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to May 18, 1922, that I last saw h[illegible] alive on May 18, 1922 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) M J McAvoy M. D.

May 19 1922 (Address) 839 S. Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	May 20 1922
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64478 — 129 — D 64478

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Frisby ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas O Ross

(a) RESIDENCE. No. 2823 Frisby ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. Information carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. Exact statement of OCCUPATION should be

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64479

D 64479

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N Glover ST., 6 WARD)

2-FULL NAME Anne K. Koch

(a) RESIDENCE NO. 405 N Glover ST., 6 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A Koch

6 DATE OF BIRTH (month, day, and year) June 12. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
	42	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Alice Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) George A Koch 405 N Glover St

15 MAY 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to May 20, 1922, that I last saw her alive on May 20, 1922, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? physical exam

(Signed) J Wade, M. D.

May 20 1922 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL May 23 19

20 UNDERTAKER Louis Heeman ADDRESS 32 S Broadway

N. B.—WRITE PLAINLY, WITH INK. All questions should be carefully answered and data carefully supplied. AGE should be stated EXACTLY; THIS IS IMPORTANT. Exact information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64480

CERTIFICATE OF DEATH.

13 D 64480
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 514 Harris alley ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Smith

(Residence in Baltimore: No. 514 Harris alley St.; yrs., 4 mos. 15 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, ... Jan. 5 (Month), ... (Day), 1922 (Year)

7-AGE, ... yrs. 4 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Cleveland Owens

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Enid Smith

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cleveland Owens

(Address) 514 Harris alley

MAY 21 1922
Filed....., 191.....

ROBERT R. KRAUSE
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May 20 (Month), ... (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro - enteritis

..... (Duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary) no history

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

May 21, 1922 (Address) 2802 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery DATE OF BURIAL, May 20 1922

20-UNDERTAKER Edward Ringgold ADDRESS 1463 Carey St

D 64481

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 64481

REGISTERED No. C 831

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2435 Hoffman St.; 8 WARD)

2-FULL NAME Ruth N. Heil

(Residence in Baltimore: No. 2435 E. Hoffman St; St.; 22 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: W

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: Dec 1 (Month), 1900 (Year)

7-AGE: 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balt Md

PARENTS

10-NAME OF FATHER: Jos. A Heil

11-BIRTHPLACE OF FATHER (State or country): Cecil County

12-MAIDEN NAME OF MOTHER: Elizabeth Gleason

13-BIRTHPLACE OF MOTHER (State or country): Harford Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jos A. Heil
(Address): 2435 Hoffman st

15 MAY 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 5 (Month) 18 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1, 1922, to 5-18, 1922, that I saw h[illegible] alive on 5-17, 1922, and that death occurred, on the date stated above, at 630 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(Duration) yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. J. France M. D.

5/21, 1922 (Address) 2939 Mc Elderry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 22, 1922.

20-UNDERTAKER: Georg. J. Ruth

ADDRESS: 1235 Harford Ave.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INDELIBLE PENCIL

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64482

D 64482

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Barclay St ST.: 17 WARD)

2-FULL NAME Edward G Worden

(a) RESIDENCE. NO. 2000 Barclay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Worden

6 DATE OF BIRTH (month, day, and year) Feb 16 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retind police Officer

(b) General nature of industry, business, or establishment in which employed (or employer) 561

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Worden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Corey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Howard Worden
(Address) 2000 Barclay St

15 Filed MAY 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to May 19, 1922, that I last saw him alive on May 19, 1922, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia. 0781
stricken in his office & did not regain consciousness (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Died after 4 hours. (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem.	May 23 1922
20 UNDERTAKER	ADDRESS
E Le Roy Stiffler	125 E. North Ave

N. B.—WHITE PAPER, BLACK INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

Spec.—1-10-21—M&T—1500 Bks.

D 64483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 64483

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 722 E 23rd (St.) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Wisthoff

(a) RESIDENCE NO. 722 E. 23rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFAILING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Aug 24—1918

7 AGE — Years: 3 — Months: 8 — Days: 26 — If LESS than 1 day, ...hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Reuben Wisthoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Mary Finnegan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant (Address): Reuben Wisthoff 722 E. 23rd st

15 MAY 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19th, 1922, to May 19th, 1922, that I last saw her alive on May 19th, 1922, and that death occurred, on the date stated above, at 11.20P m.

The CAUSE OF DEATH* was as follows:

Convulsions (Brain) 16 hours.

(duration) yrs. mos 16 hours.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 4 hours

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. E. Eisely, M. D.

, 19 (Address) 918 E. Hunt Mr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: May 22 1922

20 UNDERTAKER: H. E. Sidmarsh — ADDRESS: North Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The deceased apparently a well nourished child was taken with convulsions at 7.9 am May 19th 1922. The convulsions although given regard until death at 11.20 P.M. There were no other symptoms present except the above but no diagnosis made of the case was of a gastro-intestinal origin

Spec.—1-10-21—M&T—1500 Bks.

D 64484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 64484

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 80 E Hamilton ave ST., 11 WARD)

2-FULL NAME Lydia S. Cox

(a) RESIDENCE NO. 80 E Hamilton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John T. Cox

6 DATE OF BIRTH (month, day, and year) August 25th 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	80	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Joseph Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Biddison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Tillie C. Eyer

(Address) 80 E Hamilton ave

15 MAY 21 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922 to May 20, 1922

that I last saw h. alive on May 20, 1922

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Cerebral Hemorrhage)

(duration) — yrs. — mos. 10 hours ds.

CONTRIBUTORY (Secondary) Apoplexy (Cerebral Hemorrhage) (duration) — yrs. — mos. 10 hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

5/21 1922 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: May 23rd 1922

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 Monument st

Spec.—1-10-21—M&T—1500 Bks.

D 64485

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64485

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospitals

CITY OF BALTIMORE: (No.) ... ST., 22 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Leonard

(a) RESIDENCE NO. 10 W Conway ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ... 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hosp. Record

15 MAY 22 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922 to May 19, 1922

that I last saw him alive on May 19, 1922

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Bacterial endocarditis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

Syphilitic (duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Aut.

(Signed) Clyde McNeil M. D.

5/20 19* (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct

DATE OF BURIAL: May 22 1922

20 UNDERTAKER: J. H. Broun & Son

ADDRESS: 108 N. Monty

Spec.—1-10-21—M&T—1500 Bks.

D 64486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 D 64486

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 Biddle St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Felpta~~ Filtah Woolford

(a) RESIDENCE NO. 334 Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE ITEMS ASKED FOR MUST be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/1/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER John Woolford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Woolford (Address) 334 Biddle St

15 MAY 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/1922

17 I HEREBY CERTIFY, That I attended deceased from 5/17, 1922, to 5/21, 1922, that I last saw him alive on 5/21, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Measles Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

, 19 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	May 22 1922
20 UNDERTAKER	ADDRESS
J. L. Broadwell Son	1618 W. Pratt

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

How much slightly
about this would say,
the pneumonia was
not due directly to
the measles. Ellis.

Spec.—1-10-21—M&T—1500 Bks.

D 64487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 64487

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 117 S Carlton ST., 18 WARD)

2-FULL NAME Wm F. Cline

(a) RESIDENCE NO. 117 S. Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widr

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 26, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	25	

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Samuel Cline

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie W Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Samuel Cline (Address) 117 S Carlton St

15 MAY 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/20/22, 19.., to 5/20/22, 19.., that I last saw him alive on 5/20/22, 19.., and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Malnutrition)

(duration) thirty yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J Tenny M. D.

5/22/1922 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL May 23 1922

20 UNDERTAKER John J Fields — ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pernicion & Coma Drunk

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64488

CERTIFICATE OF DEATH.

D 64488

179

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Woodall

(a) RESIDENCE. NO. Unknown ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos ..... ds

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Samuel Woodall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Jane Lyeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant: Hospital Records.

(Address): Municipal Hospital.

15 MAY 22 1922

MAY 22 1922 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2 1921 to May 19 1922

that I last saw her alive on May 19 1922

and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Report

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D

5/20/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery DATE OF BURIAL: May 22 1922

20 UNDERTAKER: Harry A. Witzke ADDRESS: 1531 W. Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64489

CERTIFICATE OF DEATH.

32 D 64489

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Vincent ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Murphy.

(Residence in Baltimore: No. 221 Vincent St. St.; ....yrs., 6 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. .....ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Michael A. Murphy.

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Catherine Rendell

13-BIRTHPLACE OF MOTHER (State or Country), ~~Balto~~ England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael A. Murphy

(Address) 221 S. Vincent St

15- MAY 22 1922 Filed ....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 1922, to May 19 1922, that I saw her alive on May 19 1922, and that death occurred, on the date stated above, at 505 P m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Edgar E. Travers M. D.

May 19, 1922 (Address) 1521 N. Rollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Cathedral Cemetery — DATE OF BURIAL, May 22, 1922

20-UNDERTAKER Harry H. Witz — ADDRESS 1531 Lanvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64490

REGISTERED NO. 91-D 64490

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N. Carrollton Ave ST. 16 WARD)

2-FULL NAME Joseph D. Daughton Sr.

(a) RESIDENCE NO. 921 N. Carrollton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christine Daughton

6 DATE OF BIRTH (month, day, and year) Sept. 25th 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman for

(b) General nature of industry, business, or establishment in which employed (or employer) United Fruit Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Towson
(State or country) Md.

PARENTS

10 NAME OF FATHER Dixon Daughton

11 BIRTHPLACE OF FATHER (city or town) Towson
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Tinsley

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Christine Daughton
(Address) 921 N. Carrollton Ave.

15 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MAY 22 1922

MAY 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to May 19, 1922.

that I last saw him alive on May 19, 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

several years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Insanity
(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E. Finkenaur M. D.

May 20th, 1922 (Address) 2002 N Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL May 22nd 22

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 Mott St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64491

CERTIFICATE OF DEATH.

65 001 D 64491

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1416 E Biddle ST.; 10 WARD)

2-FULL NAME Norman Lee Salon

(a) RESIDENCE. NO. 1416 E Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 18th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Lee J Salon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eva Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Lee J Salon 1416 E Biddle St

15 Filed MAY 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 20, 1922, that I last saw him alive on May 19, 1922, and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH was as follows: Acute Lymphatic Leucemia

Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Study

(Signed) W R Ingram M. D.

, 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 22 1922

20 UNDERTAKER Robt E Turner & Son — ADDRESS 1442 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64492

CERTIFICATE OF DEATH.

90 ✓ D 64492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 McHenry ST., 20 WARD)

2-FULL NAME Joseph Bily Sr.

(a) RESIDENCE NO. 1827 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? 34 yrs. 6 mos. 26 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Bily

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	70	3	22	

8 OCCUPATION OF DECEASED 088

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Horazdovic Bohemia

PARENTS

10 NAME OF FATHER Thomas Bily

11 BIRTHPLACE OF FATHER (city or town) (State or country) Horazdovic Bohemia

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Jos Bily Jr.

(Address) 604 N. Potomac St

15 Filed MAY 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to May 20, 1922, that I last saw h in alive on May 16, 1922, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease Mit.

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) Dropsy - asthenia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O F Roeder M. D.

, 19 (Address) 1954 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL May 23 1922

20 UNDERTAKER Frank Enoch Son — ADDRESS 1906 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64493

CERTIFICATE OF DEATH.

100-81

D 64493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 934 Pierce ST., 18 WARD)

2-FULL NAME Walter Stanley Welch.

(a) RESIDENCE NO. 934 Pierce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William T Welch

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Butler

13 BIRTHPLACE OF MOTHER (city or town) Cornwall Co. (State or country) Md

14 Informant Minnie Welch
(Address) 934 Pierce

15 Filed MAY 22 1922 ROBERT R. KRAUTER Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922, to May 19, 1922, that I last saw him alive on May 19, 1922, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

Acute Bronchitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Walter Jr Yeary, M. D.

, 19 (Address) 16 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 22, 1922.

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 1114 W. Saratoga St

Spec.—1-10-21—M&T—1500 Bks.

D 64494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64494

CERTIFICATE OF DEATH.

179

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 21 WARD)

2-FULL NAME Leo. Boongli

(a) RESIDENCE NO. 1108 E. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Mary Boongli

6 DATE OF BIRTH (month, day, and year): Jan 20-1880

7 AGE: Years 42 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk. 09
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Mrs. Mary Boongli
(Address): 1108 E. Carey St.

15 MAY 22 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-20 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-3, 1922, to 5-20, 1922, that I last saw him alive on 5-22, 1922, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis - Myocarditis
Arteriosclerosis - Chr. Nephritis

not known (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Exacerbation of this
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical - Laboratory

(Signed) J. D. Baldwin, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 5/23 19 22

20 UNDERTAKER: William Cook

ADDRESS: 501 Park

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

178 D 64495

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Booker

(a) RESIDENCE. No. 426 Wesley St. WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE Black

5 Single, ~~Married~~, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Booker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Laura Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Albert Booker
(Address) 426 Wesley St

15 Filed MAY 22 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1922, to May 20, 1922, that I last saw him alive on May 20, 1922, and that death occurred, on the date stated above, at 1100 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis and Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart

(duration) 1 yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? X

What test confirmed diagnosis? Autopsy Dr. Hurd Hall

(Signed) Hurd Hall, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	5/24 19
20 UNDERTAKER William Cook	ADDRESS 502 E Nort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64496

CERTIFICATE OF DEATH.

90 ✓ D 64496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 West Mulberry ST. 20 WARD)

2-FULL NAME Arthur M. Standiford

(a) RESIDENCE NO. 1832 West Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, (or) WIFE of: M. Valerie Standiford

6 DATE OF BIRTH (month, day, and year): July 6 - 1880

7 AGE: Years 41; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Agt

(b) General nature of Industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Adolphus Standiford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Sarah E. Mackey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: M. Valerie Standiford

(Address) 1832 W. Mulberry

15 Filed MAY 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to May 20, 1922, that I last saw him alive on May 19, 1922, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Probable (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) J. H. Staunsbury M. D.

May 21 1922 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 5/22/19

20 UNDERTAKER: Williams Cook — ADDRESS: 502 [illegible]

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64497

CERTIFICATE OF DEATH.

D 64497

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1852 N. Wolfe St. (ST.:) 8 (WARD)

2-FULL NAME Mary Virginia Hartman

(a) RESIDENCE. NO. 1852 N. Wolfe St. STS. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of John L. Hartman

6 DATE OF BIRTH (Month) April (Day) (Year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Benjamin F. Wooten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Regina Ralz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John L. Hartman (Address) 1852 N. Wolfe St

15 Filed MAY 22 1922 ROBERT F. WOOTEN Registrar of Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) May (day) 20 (year) 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to May 20 1922,

that I last saw her alive on May 20 1922,

and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Warfield Hartman M. D.

5/20/22 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 24 1922
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Madison

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64498

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 East Biddle St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Buckler Willson

(a) RESIDENCE. NO. 6 East Biddle ST., 11 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, ~~or divorced~~
HUSBAND of ~~(or, WIFE of)~~ Nannie W. Tyson Willson

6 DATE OF BIRTH (month, day, and year) 1846-2-17

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Importer of 045

(b) General nature of industry, business, or establishment in which employed (or employer) Coffee & Sugar.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Francis W. Willson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Tyson Willson
(Address) 6 East Biddle St.

15 MAY 22 1922 ROBERT R. KRAUSE Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21-1922

17 5-21-1922

I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to May 20, 1922, that I last saw h— alive on May 20, 1922, and that death occurred, on the date stated above, at 4:15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis + arterio Sclerosis

Pulmonary Oedema

(duration) 1 yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Clinical

(Signed) C. H. McElfresh, M. D.

, 19 (Address) 1415 Linden ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	5-23 1922
20 UNDERTAKER	ADDRESS
Harry A Jenkins Mortuary Co	1 E Fallsway

Orchard.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64499

CERTIFICATE OF DEATH.

89 D 64499

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 SO. CHESTER ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME VICTOR KRAUS,

(a) RESIDENCE No. 521 SO. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 17 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katkerine Kraus,

6 DATE OF BIRTH (month, day, and year) March **** 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer, 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Frank Kraus,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Katherine ******

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant (Address) Katherine Kraus, (Wife) # 521 So. Chester Street

15 Filed MAY 22 1922 ROBERT R. KNOTTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19. 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1922, to May 19, 1922, that I last saw h alive on May 19, 1922, and that death occurred, on the date stated above, at 11.00 P- m.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 20, 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL May 23 1922

20 UNDERTAKER W. F. Sadowski. ADDRESS 905 S. Ann St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64500

D 64500

CERTIFICATE OF DEATH.

49

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1538 N. Milton Ave St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Gallicoffer Crane

(Residence in Baltimore: No. 1538 N. Milton Ave St.; 20 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Feb (Month) 22nd (Day), 1862 (Year)

7-AGE, 60 yrs. 2 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: State Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) St. Mary's Co. Md.

PARENTS.

10-NAME OF FATHER, John A. Crane

11-BIRTHPLACE OF FATHER (State or Country) St. Mary's Co. Md

12-MAIDEN NAME OF MOTHER, Phillamina Smith

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Crane

(Address) 1538 N. Milton Ave.

15- Filed MAY 22 1922, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 20th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20 1922, to May 20 1922, that I saw him alive on May 20th 1922, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. 1 mos. ds.

(Signed) J. Culbertson M. D.

5/21, 1922 (Address) 1901 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Michael Cem St Mary's Co

DATE OF BURIAL, May 22, 1922

20-UNDERTAKER Wm C. Miller

ADDRESS 2334 Jefferson St

John J. Hohman Sr

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64501

CERTIFICATE OF DEATH.

185 D 64501

REGISTERED NO C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2003 monument St.; WARD)

2-FULL NAME John J Hohman Sr

(Residence in Baltimore: No. 2003 monument St.; yrs., 4½ mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word): Married

6-DATE OF BIRTH: November 24th, 1859
(Month) (Day) (Year)

7-AGE: 62 yrs. 5 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Park Packer.
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Conrad Hohman

11-BIRTHPLACE OF FATHER (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Henrietta Kinstler

13-BIRTHPLACE OF MOTHER (State or Country): Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mrs Alice Hohman

(Address) 2003 E. Monument St

15-

Filed MAY 22 1922 191.. ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock
Acute dilation Heart
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balto. Cemetery

DATE OF BURIAL, May 22, 1922

20-UNDERTAKER Wm. J. Scharff 1816 E. Monument St

ADDRESS

Burial Permit

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64502 D 64502

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 51 Forrest View Ave ST. N 1 WARD) (Belvar)

2-FULL NAME Annie M. Alexander

(a) RESIDENCE NO. 51 Forrest View Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: late Thos. Alexander

6 DATE OF BIRTH (month, day, and year): Feb 16 - 48

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John D. Lowrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca W. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Nora S. Alexander
(Address) 51 Forrest View ave.

15 MAY 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1922

17

I HEREBY CERTIFY, That I attended deceased from 5-10 1922 to 5/20 1922,

that I last saw h[illegible] alive on 5-18 1922,

and that death occurred, on the date stated above, at 11:10 A. m.

The CAUSE OF DEATH* was as follows:

Chron Endocarditis

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Ascending P. Orleans

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) G. Jones, M. D.

5/21, 1922 (Address) 2439 W Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: May 23 1922

20 UNDERTAKER: Philip Herwig — ADDRESS 2046 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75, 90 64503

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823-Linden-Ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Mantz Boyd.

(a) RESIDENCE. No. 1823-Linden-Av. ST., 14 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 69 yrs. 11 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) May-28-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Frederick, Maryland

PARENTS

10 NAME OF FATHER Andrew Boyd

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Caroline Mantz

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Maryland.

14 Informant David Boyd, (brother)
(Address) 1823-Linden-Av., City.

15 Filed MAY 22 1922 ROBERT R. KNOTEN, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 1922 to May 24 1922 that I last saw h-- alive on May 24 1922 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Dropsy (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Progressive Paralysis (Hemiplegia) (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of -

Was there an autopsy? No.

What test confirmed diagnosis? Usual Examination

(Signed) R. B. Norment, M. D.

May 22, 1922 Address) 3043 Clermont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet, Frederick, Md.	May-23-22

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODER, [redacted])

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. E TION is very important. See instructions on back of certificates.

T. ... State ... nt of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64504

CERTIFICATE OF DEATH.

111 - 681 - D 64504

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: VV WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Thomas Byrnes

(a) RESIDENCE. NO. ~~2111~~ 3001 Abell Av ST., 12 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 47 yrs. 6 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Maguire Byrnes

6 DATE OF BIRTH (month, day, and year) Nov-15-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commercial Traveler. State

(b) General nature of industry, business, or establishment in which employed (or employer) C. M. Kemp Manufacturing Company

(c) Name of employer

9 BIRTHPLACE (city or town) New York

(State or country) New York

PARENTS

10 NAME OF FATHER Thomas Byrnes

11 BIRTHPLACE OF FATHER (city or town) Rostmore

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Davis

13 BIRTHPLACE OF MOTHER (city or town) Rostmore

(State or country) Ireland

14 Informant Mrs Katherine M. Byrnes Wife

(Address) 3001 Abell Ave City

15 MAY 22 1922 Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922, to May 21, 1922, that I last saw h~~im~~ alive on May 21, 1922, and that death occurred, on the date stated above, at 8.45 p m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

over

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 3001 Eagle ave

Did an operation precede death? Yes Date of May 18 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Thos W Peters, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery. DATE OF BURIAL: May 24 1922

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Manager) ADDRESS: 106 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant
as far as pathy could
determine.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64505

CERTIFICATE OF DEATH.

D 64505

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1214 McCulloh ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie E. McCorkle

(a) RESIDENCE. No. 1214 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 8-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Slaughterer

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Saml. R. McCorkle

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Sarah Beattie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Sarah B. McCorkle (Address) 1214 McCulloch St.

15 Filed MAY 22 1922 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-1922

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1922, to May 20, 1922, that I last saw h[illegible] alive on May 19th, 1922, and that death occurred, on the date stated above, at 1.40 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 5 yrs. Maryland

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) [illegible] M. D.

, 19 (Address) 1540 N. Bidde[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 22 1922

20 UNDERTAKER Jno. M. Johnson

ADDRESS Cotting St.

D 64506 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 D 64506

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1513 N Milton ave St.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J Lanahan

(Residence in Baltimore: No. 1513 N Milton ave St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: W

5-MARRIED ~~WIDOWED DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: June 8, 1872 (Month) (Day) (Year)

7-AGE: 49 yrs. 11 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Tob

9-BIRTHPLACE (State or country): New York N.Y.

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth R. Lanahan

(Address) 1513 N. Milton ave

15 Filed MAY 22 1922 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1922 to May 19 1922; that I saw h in alive on May 19, 1922; and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds

Contributory (SECONDARY) Cardiac Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A J Powers M. D.

May 20, 1922 (Address) 921 N Chas

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 5/23, 1922

20-UNDERTAKER: Chas. F. Powers & Son

ADDRESS: 118 W Mt Royal ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64507 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64507

CERTIFICATE OF DEATH.

452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Eastern Ave. ST.: 2 WARD)

2-FULL NAME Bernard J. Landman

(a) RESIDENCE. No. 2006 Eastern Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Landman

6 DATE OF BIRTH (month, day, and year) Unknown 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	—	—	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Landman (Address) 2006 Eastern Ave

15 Filed MAY 22 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20/22 19

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 22, to May 20, 19 22 that I last saw h— alive on May 24, 19 22 and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Rectal Cancer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

May 24, 19 22 (Signed) J. Hanson, M. D. (Address) 1122 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	5/23/22 19

20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son,	118 W. Mt. Royal Ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64508

CERTIFICATE OF DEATH.

31

D 64508

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 S. Ewley, ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Rolfes.

(a) RESIDENCE NO. 614 S. Ewley ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Rolfes.

6 DATE OF BIRTH (month, day, and year) May 15th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	44		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 307

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Saleski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ulkmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George A Rolfes

(Address) 614 S Ewley St

15 Filed MAY 22 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to May 20, 1922, that I last saw h[illegible] alive on May 19, 1922, and that death occurred, on the date stated above, at 9 10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arthur E Hearn M. D.

5/22 1922 (Address) 2600 E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 23rd 1922
20 UNDERTAKER	ADDRESS
Lilly & Feiler	403 S. Wolfe

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64509

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1324 N. Lafayette Ave ST. 16 WARD)

2-FULL NAME John. L. Lang.

(a) RESIDENCE. No 1324 N Lafayette Ave ST.....WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amelia G Lang.

6 DATE OF BIRTH (month, day, and year) May 23 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	11	28	

8 OCCUPATION OF DECEASED 030

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) School House

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John. G. Lang.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Ann. Seibel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant H Thompson Lang
(Address) 1324 N Lafayette ave

15 MAY 22 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17

I HEREBY CERTIFY, That I attended deceased from May 1 1919 to May 21 1922 that I last saw him alive on May 19 1922 and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart.
Mitral Insufficiency.
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial Nephritis
(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Murray M. D.

May 21 1922 (Address) 1321 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	5-24-1922

20 UNDERTAKER Mrs. Chas. A G Rohde ADDRESS 600 N. Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

12

D 64510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 64510

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 523 W. Biddle St. St. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warrington Keyes

(Residence in Baltimore: No. 523 W. Biddle St.

St.; yrs 33 mos. 2 ds. 4)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) single

6-DATE OF BIRTH, March 15, 1889
(Month) (Day) (Year)

7-AGE, 33 yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Keyes

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sallie Simpson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie Keyes

(Address) 508 Tyson St.

15- MAY 22 1922 ROBERT R. KRAUTER.
Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

Duration 4 hrs

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

May 22, 1922 (Address) 2302 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Royal | DATE OF BURIAL, May 24 1922

20-UNDERTAKER Edward Hensley | ADDRESS 1911 Division St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64511

CERTIFICATE OF DEATH.

REGISTERED NO. 69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Orleans ST.; 6 WARD)

2-FULL NAME Mary Alice Frank

(a) RESIDENCE. NO. 1920 Orleans St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 8, 18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10		

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Robert Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Robt Frank
(Address) 1920 Orleans

15 MAY 22 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1922, to May 20, 1922, that I last saw her alive on May 20, 1922, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Whooping Cough.
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia
(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Lloyd, M. D.

May 20, 1922 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: May 23 1922

20 UNDERTAKER: John Emrich — ADDRESS: 2008 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64512

CERTIFICATE OF DEATH.

74-801 D 64512

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Donohue

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pennsylvania.

PARENTS

10 NAME OF FATHER John Donohue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 MAY 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13 1922 to May 18 1922, that I last saw him alive on May 18 1922, and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

5/19/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS MAY 2 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64513 CERTIFICATE OF DEATH. 129 D 64513

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Hurst

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital.

15 MAY 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922 to May 19, 1922.

that I last saw him alive on May 19, 1922.

and that death occurred, on the date stated above, at 3:05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? W. & N.

(Signed) Clyde McNeil M. D.

5/20/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL MAY 22 1922

20 UNDERTAKER

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64514

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 Eaton Ave St.; 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elana H. Cross

(a) RESIDENCE. No. 716 Eaton Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Cross

6 DATE OF BIRTH (month, day, and year): Jan 31 1865

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Chas Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Bamble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mary Hamilton (Address) 716 Eaton ave

15 Filed MAY 22 1922 ROBERT R. KRAUTH, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21. 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 6th, 1922, to May 21st, 1922, that I last saw h[illegible] alive on May 19th, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilation (Valvular)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination & Clinical signs.

(Signed) Russell Fargo, M. D.

19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Waverly	May 23 1922
21 UNDERTAKER	ADDRESS
E. A. Wiedefeld & Son	501 E 22d

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64515

REGISTERED NO. 90D 64515

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3944 Elm Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Hauschel

(a) RESIDENCE. No. 3944 Elm Ave ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katrina Hauschel

6 DATE OF BIRTH (month, day, and year) May 22 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter, O I V

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Mrs. Katrina Hauschel (Address) 3944 Elm Ave

15 Filed MAY 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922 to May 21, 1922, that I last saw h— alive on May 21, 1922, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart —

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam —

(Signed) R. B. Norment, M. D.

(Address) 3943 Chesterfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 24 1922

20 UNDERTAKER Geo. P. Schwab

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 64516

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1612 N Monroe ST.: 15 WARD)

2-FULL NAME John T. Sheets

(a) RESIDENCE. No. 1612 N. Monroe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred nearly all Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Annie Sheets

6 DATE OF BIRTH (month, day, and year) May 18-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	70	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Lafayette Lumber Mill

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER Jacob Sheets

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George E Shannon

(Address) 700 Fulton Ave

15 MAY 22 1922 ROBERT N. KNOTTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 1922, to May 20, 1922, that I last saw him alive on May 19, 1922, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ✓ yrs. 6 mos. ✓ ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George E. Shannon, M. D.

5/20 1922 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 23 1922
20 UNDERTAKER	ADDRESS
W. M. Routson	2258 W N Avenue

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64517

CERTIFICATE OF DEATH.

179 D 64517

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4024 Forest Park Ave ST. 15 WARD)

2-FULL NAME Friedericka G. Meyer.

(a) RESIDENCE NO. 4024 Forest Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Meyer.

6 DATE OF BIRTH (month, day, and year) 17 March 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Chas. H. Fechler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Eliz. Bertram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John F. Meyer.

(Address) 4024 Forest Park Ave.

15 Filed MAY 2 1922 ROBERT R. KNAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from 21 May 3. P. m., 1922, to May 21 4. P. m. 1922.

that I last saw h[illegible] alive on May 21, 1922,

and that death occurred, on the date stated above, at 5. 8. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Hosp Surgn M. S. Schumacher M. D.

19 (Address) 3101 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cremation Lauden Park — DATE OF BURIAL: May 23 1922

20 UNDERTAKER: Frank A. Fink — ADDRESS: 910 W. Gay St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D 64518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 64518

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 211 No Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Johnson

(Residence in Baltimore: No. 361 O'Brien St. Waverly St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH, Dec 29, 1872 (Month) (Day) (Year)

7-AGE, 29 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Sophia Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W C Brooks

(Address) Sparks

15 MAY 22 1922 Filed, 191.

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

by accident (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Knox Insley M. D. (Coroner)

5-22-1922 (Address) Sparks

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Stowell Chapel Balto Md. DATE OF BURIAL, 19 22

UNDERTAKER, W C Brooks ADDRESS Sparks Md

Important. See instructions on back of certificate.

D 64519

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64519

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3423 Hudson St. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Flury.

(a) RESIDENCE NO. 3423 Hudson St. ST., 76 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Flury.

6 DATE OF BIRTH (month, day, and year) March 2-1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Mackessy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose O'Neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Andrew Flury.

(Address) 3423 Hudson St.

15 Robert P. Harrison, 19

Registrar

Burial Permit Clerk.

MAY 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17

I HEREBY CERTIFY, That I attended deceased from 5/12/22 19 to 5/19/22 19

that I last saw her alive on 5/19/22 19

and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. McGarrell M. D.

5/20 1922 (Address) 633-5-304 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL May 23 1922

20 UNDERTAKER Lilly & Feiler ADDRESS 403 S. Wolfe St.

R.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64520

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 64520

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST., 24 WARD)

2-FULL NAME Mrs. Christina Brown

(a) RESIDENCE NO. 105 Fort ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, with pen and ink. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY as near as information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Henry Brown

6 DATE OF BIRTH (month, day, and year) June 10, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Fredenwald

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mercy Hospital Records
(Address)

15 MAY 22 1922 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to May 20, 1922

that I last saw her alive on May 20, 1922,

and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene Right Foot

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? Hom

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign & Symptoms

(Signed) John L. Corbin, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL May 23 1922

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 N. Gilmor St.

D 64521

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 64521

1 PLACE OF DEATH — REGISTERED NO. C 74

CITY OF BALTIMORE (No. 1213 Linden Av ST.: 11 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Theresa Amberg Franz

(Residence in Baltimore: No. 1213 Linden Ave St.: 75 yrs. 1 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: March 26, 1846 (Month) (Day) (Year)

7 AGE: 76 yrs. 1 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Neuses - Germany

PARENTS

10 NAME OF FATHER: Kristian Amberg

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Veronica Anna Brezinger

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jr. Geo. Franz

(Address) 3038 Windsor ave

15 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MAY 22 1922, 191

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 21, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922, to May 21 1922, that I saw her alive on May 20, 1922, and that death occurred, on the date stated above, at 4.05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 5 ds

Contributory (SECONDARY) Mitral Regurgitation

(Duration) 5 yrs. mos. ds.

(Signed) Lewis M. Gerstenfeld M. D.

May 21, 1922 (Address) 1505 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 5/24, 1922

20 UNDERTAKER: Geo. A. Kelly — ADDRESS: 1300 Fayette

WHITE PERMANENT — N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Maria Geter) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE, 081

D 64522 — D 64522

CERTIFICATE OF DEATH.

REGISTERED NO. 14

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Geter.

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tilman Geter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 63	—	—	—	

Unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) State of Virginia

PARENTS

10 NAME OF FATHER Thomas Monkman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Fanny Monkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sr. Florence, (Address) Preston & Valley

15 Filed MAY 22 1922 Filbert P. Harrison, Registrar

Burial Permit Clerk

N. B.—WRITE PLAINLY. With exception of [illegible] mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw her alive on May 16, 1922

and that death occurred, on the date stated above, at 9 45 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

May 24, 1922 (Address) 1130 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: May 24 1922

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 725 Oakland Ave

Spec.—1-10-21—M&T—1500 Bks.

D 64523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64523

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 W 37 ST., 12 WARD)

2-FULL NAME Margaret Augusta Wenzel

(a) RESIDENCE NO. 822 W 37 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK. Every question should be stated EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua H Wenzel

6 DATE OF BIRTH (month, day, and year) Feb 5 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joshua Wenzel (Address) 822 W 37 St

15 Robert P. Harrison, Registrar

MY 22 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 10 1922, to May 20 1922, that I last saw h[illegible] alive on May 20 1922, and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. according to history mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Specimen

(Signed) H Arthur Darby, M. D.

, 19 (Address) 1611 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 23, 1922

20 UNDERTAKER Cheeseworth & Son — ADDRESS Chestnut Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64524

D 64524

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1633 (St.) Thomas Ave (Ward) 15

2-FULL NAME Mary M. Goodman

(a) RESIDENCE. (No.) 1633 Thomas Ave. (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel E. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Hannabrugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Rose M. Goodman 1633 Thomas Ave

15 Filed MAY 22 1922, 19 Rose P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13th, 1922, to May 22nd, 1922, that I last saw her alive on May 21st, 1922, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows: Chronic valvular heart disease with atheroma of arteries.

(Duration) for several yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Malarial fever. (duration) + yrs. + mos. 7 ds.

Remittent

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No laboratory.

(Signed) O. St. Hoffman, M. D.

, 19 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park May 24	19 22

20 UNDERTAKER H.C. Wiedefeld 914 Greenmt Ave

ADDRESS

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS ... stated EXACTLY. PHYSICIAN should mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

MAY 22 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64525

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64525

101-001

CERTIFICATE OF DEATH.

REGISTERED No. 1943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 E. Greene ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M. Deaton, Jr.

(a) RESIDENCE. No. 226 E. Greene ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edna Mural Deaton

6 DATE OF BIRTH (month, day, and year): March 17-1894

7 AGE: Years 28; Months 2; Days 3; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerical Work

(b) General nature of industry, business, or establishment in which employed (or employer): American Express Co.

(c) Name of employer: Janes Steel (a Co.)

9 BIRTHPLACE (city or town) (State or country): Hope Mill N. C.

PARENTS

10 NAME OF FATHER: James M Deaton

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edna M Deaton

(Address): 226 E. Green St

15 Filed MAY 22 1922

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922, to May 20, 1922, that I last saw him alive on May 20, 1922, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cold + Exposure 3 weeks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Test

(Signed) Geo. A. Deaton M. D.

, 19 (Address) 1023 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jacksonville Flu.

DATE OF BURIAL: May 23 1922

20 UNDERTAKER: George J. Smith.

ADDRESS: 1000 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. AGE should be stated in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. SIGNATURE is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 64526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64526

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 East Cross ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth T. Robbins

(a) RESIDENCE. NO. 418 East Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Widow

6a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Richard J Robbins

6 DATE OF BIRTH (month, day, and year) 3-4-1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs J Robbins
(Address) 614 N Milton St

15 Filed May 23 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1922, to May 20, 1922, that I last saw h~~er~~ alive on May 20, 1922, and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) L L Burton, M. D.

5/20/1922 Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: May 23. 1922

20 UNDERTAKER: Margaret E. Flynn

ADDRESS: 1111 E Fayette St

Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

MAY 22 1922

Spec.—6-9-19—H. P. Co.—1600 Bks.

D 64527

HEALTH DEPARTMENT—CITY OF BALTIMORE

44D 64527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Lee.

(a) RESIDENCE. No. 1227 Etting St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Adam Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Harannah Lee

(Address) 319 W Huffman st

15 Filed MAY 22 1922 19 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/28/ 1922, to 5/19 1922,

that I last saw h[illegible] alive on 5/19 1922,

and that death occurred, on the date stated above, at 10½ P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach with metastasis to liver.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Leon Bridges M. D. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 5/23 19

20 UNDERTAKER: Joh B. Pye — ADDRESS: 102 E. Mulberry st

B.—WRITE PLAINLY. WITH [illegible] should be stated. EXACT... mation should be carefully supplied. AGE... it may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it ma... TION is very important. See instructions on ba... on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.VETERANS' HOSP.#56, REGISTERED NO. 24 X 177

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES A. MUHLEISEN,

(a) RESIDENCE NO. Crum Lynne, Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipbuilder

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) --

12 MAIDEN NAME OF MOTHER ---

13 BIRTHPLACE OF MOTHER (city or town) (State or country) --

14 Informant HOSPITAL RECORDS, (Address) FORT McHENRY,Md.

15 Filed MAY 22 1922, 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922, to May 20, 1922, that I last saw him alive on May 20, 1922, and that death occurred, on the date stated above, at 7:10 p m.

The CAUSE OF DEATH* was as follows:

Muriatic acid poisoning
Taken in mistake for Whiskey
Accidental death
No Inquest necessary

Otto M Reinhardt Coroner

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Peritonitis, gastric hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special test

(Signed) M. H. Fogler, M. D.

5/23/22 (Address) SURGEON, U.S.P.H.S. Ft.McHenry,Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL May 24 1922

20 UNDERTAKER L. Harrison & Bro

ADDRESS 1127 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1801

188 D 64529

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josiah V. Bell

(Residence in Baltimore: No. 1622 Cliftview ave. St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married.

6-DATE OF BIRTH, Dec. (Month) 5 (Day), 1884 (Year)

7-AGE, 37 yrs. 5 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): U. S. A. Gov't

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Sam Bell

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Sue Emma C. Bradley

13-BIRTHPLACE OF MOTHER (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Bell

(Address) 1415 Fulton st

15- MAY 22 1922 Robert P. Harrison, 191.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) Inquest will be held May 22 1922 find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fra. of tibia and fibula also internal injuries may have had fra. of base of skull

3 hours (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

S. Frank (Duration) .....yrs.....mos.....ds.

(Signed) M. J. Ruby (Coroner) M. D.

May 21, 1922 (Address) (459 Bun)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. State 2 hrs above in the.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, May 23, 1922

20-UNDERTAKER Frank Lescalmo

ADDRESS Fulton st.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Struck by Penna. Ry. Train

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Hurley)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64530

D 64530

CERTIFICATE OF DEATH.

REGISTERED NO. 74

1-PLACE OF DEATH

CITY OF BALTIMORE. (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. 2016 W. Lanvale ST.: 16 WARD)

2-FULL NAME George L. Hurley

(a) RESIDENCE. No. 2016 W. Lanvale ST., 16 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	W	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Mary C. Hurley

6 DATE OF BIRTH (month, day, and year) May 19, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Business 1045

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Business

(c) Name of employer O. P. Hobray & Co

9 BIRTHPLACE (city or town) (State or country) Harrington Del.

PARENTS

10 NAME OF FATHER Stephen L. Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER A. D. Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Luther D. Hurley Son
(Address) 2016 W. Lanvale St.

15 Filed ..... 19 ..... Registrar

MAY 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) S. 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from S. 20, 1922, to S. 21, 1922, that I last saw h in alive on S. 21, 1922, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

24 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas L. Davis, M. D.

5.22 1922 (Address) 824 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem't	May 24 1922

20 UNDERTAKER William Cook ADDRESS 1026 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. REGISTRATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

(Dobbs) Rutledge 1623 E. N. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64531

CERTIFICATE OF DEATH.

44

D 64531

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 E Hoffman ST., 8 WARD)

2-FULL NAME William J. Dobbs

(a) RESIDENCE NO. 2040 E Hoffman ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emmetta Dobbs.

6 DATE OF BIRTH (month, day, and year) Aug 24/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington (State or country) Del

PARENTS

10 NAME OF FATHER John Dobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Emily Kenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Blanche Kline

(Address) 2038 E Hoffman

15 Filed ....., 19..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4 1922, to May 20, 1922, that I last saw h.. alive on May 20, 1922, and that death occurred, on the date stated above, at 12.35 A m.

The CAUSE OF DEATH* was as follows:

Coronary Occl

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Pneumonia + Acute Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + Symptoms

(Signed) Jay A Rutledge M. D.

May 24 1922 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlief — DATE OF BURIAL May 24 1922

20 UNDERTAKER H. M. Cole — ADDRESS Walbrook

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 22 1922 Burial Permit Clerk.

Spec. 1-10-21 M&T 1500 Bks.

D 64532

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64532

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1611 N. Gilmor ST., 15 WARD)

2-FULL NAME Claudia D. Collins

(a) RESIDENCE NO. 1611 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 If married, Widowed, or Divorced (Write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Percy G Collins

6 DATE OF BIRTH (month, day, and year) Nov 16-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	55	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER William G. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Emmi McGregor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Percy G. Collins (Address) 1611 N. Gilmor

15 MAY 22 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 17th, 1922, to May 21st, 1922, that I last saw h.. alive on May 21st, 1922, and that death occurred; on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Breast

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Her Home

Did an operation precede death? No Date of —

Was there an autopsy? — Yes

What test confirmed diagnosis? X-Ray & microscopic

(Signed) Wm G Sellman M. D.

(Address) 1701 N Charles and

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmont Frederick Co | DATE OF BURIAL 5/23 19 22

20 UNDERTAKER William Cook | ADDRESS 502 E N.

Robert P. Harrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. mation should be TION is very important.

D 64533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64533

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 606 S Smallwood St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Stockett

(Residence in Baltimore: No. 606 S. Smallwood St.; yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. July (Month) 17 (Day) 1857 (Year)

7-AGE. 62 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Street Sweeper
(b) General nature of industry, business, or establishment in which employed (or employer). City

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, James Stockett

11-BIRTHPLACE OF FATHER, (State or Country). Carroll Co

12-MAIDEN NAME OF MOTHER, Anna R. White

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Flora Stockett

(Address) 606 S Smallwood

15-

Filed ..... 192.....

Registrar.

MAY 22 1922

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 21 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 2 hrs.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D.
(Coroner.)

May 22 1922 (Address) 10 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	May 24 1922

20-UNDERTAKER,	ADDRESS
William Cook	E Fath Mt

B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64534

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 E. 20th ST., 12 WARD)

2-FULL NAME Hugh Thomson Kennedy

(a) RESIDENCE NO. 423 E. 20th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 41 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M Kennedy

6 DATE OF BIRTH (month, day, and year) Feb 8, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	3	13	

8 OCCUPATION OF DECEASED 076

(a) Trade, profession or particular kind of work Marble stone worker

(b) General nature of industry, business, or establishment in which employed (or employer) Employer

(c) Name of employer as above

9 BIRTHPLACE (city or town) Glasgow
(State or country) Scotland

PARENTS

10 NAME OF FATHER John E Kennedy

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Hannah

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Scotland

14 Informant Ann M Kennedy
(Address) 14 Queen Anne Road

15 Filed May 22 1922, 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 1922, to May 21 1922,

that I last saw him alive on May 21 1922,

and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) Robert L. Mitchell, M. D.

May 22 1922 (Address) 211 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL May 23 1922

20 UNDERTAKER Wm J Tutener & Sons

ADDRESS North Avenue

A. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64535 64535

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 760 W Mulberry ST., 17 WARD)

2-FULL NAME Joseph Wilson

(a) RESIDENCE No. 760 W Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 074

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer Ft. Geo Meyd BB

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dud Earlon
(Address) 916 Pa ave

15 Filed ....., 19 .....
MAY 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1922, to May 21, 1922, that I last saw him alive on May 21, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage
(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) non
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) H B Kenyon, M. D.

5/22, 1922 (Address) 609 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M Auburn — DATE OF BURIAL May 23, 1922

20 UNDERTAKER Dud Earlon — ADDRESS 916 Pa ave

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64536

CERTIFICATE

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1704 Laurens ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Simms

(a) RESIDENCE. NO. 1704 Laurens ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10, 1922

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				22

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Simms

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Simms

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Lenora Simms

(Address) 1704 Laurens, JOHNS

15 Filed — 19—4 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1922

17

I HEREBY CERTIFY, That I attended deceased from 1.30 a.m. March 10 1922, to 11.30 p.m. March 10, 1922, that I last saw h. alive on March 10, 1922, and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Asphyxiation caused by atelectasis and persistent pulmonary oedema

(duration) 20 yrs. 10 mos. 10 ds.

CONTRIBUTORY (Secondary) pulmonary edema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) John E. S. Compton, M. D.

, 19 (Address) 1405 Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAR 1 192

Dep. Wm. H. Welch

90

MAY 23 1922

MAY 23 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64537

CERTIFICATE OF DEATH.

X74-D 64537

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 E 20th St — St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence Conner

(a) RESIDENCE. No. 18-E-20th St., St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 26 Years — Months — Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer): House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. Carolina

PARENTS

10 NAME OF FATHER: Judge Fulwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Carolina

12 MAIDEN NAME OF MOTHER: Rotanner Robin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S Carolina

14 Informant: H Husband. Ben Conner

(Address): 18. E. 20. St- Baltimore

15 Filed: MAY 23 1922

ROBERT R. KNAUER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 18, 19 22, to May 22, 19 22, that I last saw h[er] alive on May 22, 19 22, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy. OVH

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Laura A. Johnson, M. D.

, 19 (Address) 211-E-23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leipsic Burg S. Carolina	May 23 1922
20 UNDERTAKER: Mrs Robert A. Elliott	ADDRESS: 1725- Ashland Ave

A. B. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of lues.

No history of lues

(Roeback)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64538

CERTIFICATE OF DEATH.

5-091

D 64538

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 220 W. Chase ST.: 11 WARD)

REGISTERED No. C 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary ann Roelack

(Residence in Baltimore: No. 220 W. Chase. St.; 62 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, about (Month) (Day) 1860 (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): House Work

070

9-BIRTHPLACE, (State or Country), Live City 17 years Md.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know.

12-MAIDEN NAME OF MOTHER Hattie Mack

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Roelack

(Address) 220 W. Chase St.

15- Filed MAY 23 1922, 19... ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 2 yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

May 22, 1922 (Address) 2812 Fairmount Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Basil Chapel Cemetery — DATE OF BURIAL, May 25, 1922

20-UNDERTAKER Cockeysville Md Mrs R A Elliott — ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118 / 60 V

D 64539

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 N-Spring ST., 10 WARD)

2-FULL NAME Burnice Carter.

(a) RESIDENCE NO. 1206 N-Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chield

6 DATE OF BIRTH (month, day, and year): born Aug 6. 1918

7 AGE: 4 Years 9 Months — Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chield ppp

(b) General nature of industry, business, or establishment in which employed (or employer): Chield

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): born in Balt

PARENTS

10 NAME OF FATHER: George Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Marie Venie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Sr Brother Marie Carter

(Address) 1206 N Spring St

15 Filed MAY 23 1922 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-22-19 22

17 I HEREBY CERTIFY, That I attended deceased from 5-20-, 19 22, to 5-22-, 19 22,

that I last saw h~~er~~ alive on 5-21-, 19 22,

and that death occurred, on the date stated above, at 6-A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Gargill, M. D.

, 19 (Address) 617 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: May 23. 1922

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS: 1725 Ashland Av

Spec.—8-24-14—M. & T.—2000 Bks.

D 64540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64540

CERTIFICATE OF DEATH.

44

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 Ensor ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry M Bowen

(Residence in Baltimore: No. 1316 Ensor St.; 39 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	W	Married

6-DATE OF BIRTH, April 22, 1881
(Month) (Day) (Year)

7-AGE, 41 yrs. ..... mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman Sheet Metal
(b) General nature of industry, business, or establishment in which employed (or employer): Coal & Factory

9-BIRTHPLACE, (State or Country). Calvert Co Md

PARENTS.

10-NAME OF FATHER. Jesse Bowen

11-BIRTHPLACE OF FATHER (State or Country). Calvert Co Md

12-MAIDEN NAME OF MOTHER Orrie V. Martin

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bowen

(Address) 1316 Ensor st

15- MAY 23 1922 Filed ....., 191.... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH May 21, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9 1922, to May 21 1922, that I saw him alive on May 20 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinomatosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo M Gean M. D.

May 21, 1922 (Address) 20 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, May 24, 1922

20-UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

N.B.—Every item of information called for must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Ethelinda Reed

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64541

CERTIFICATE OF DEATH.

D 64541

REGISTERED NO. C 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Myrtle ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethelinda Reed

(Residence in Baltimore: No. 1207 Myrtle St.; ....yrs., ...mos. ....ds.)

N.B.—Every item of information must be stated, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Mar (Month) 5 (Day), 1921 (Year)

7-AGE, 1 yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, H L. Reid

11-BIRTHPLACE OF FATHER (State or Country) Va

12-MAIDEN NAME OF MOTHER Marie White

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry L Reid

(Address) 1207 Myrtle

15- Filed MAY 23 1922 191.. ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 21 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1922, to May 21 1922, that I saw her alive on May 21 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ....yrs. ....mos. 5 ds.

(Signed) William E Burton M. D.

May 23 1922 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount DATE OF BURIAL MAY 23 1922

20-UNDERTAKER Samuel T Kennedy ADDRESS 578 N Eden

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 64542

CERTIFICATE OF DEATH.

101 D 64542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 S. Broadway WARD) 2

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Statter

(a) RESIDENCE NO. 11 S. Broadway WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Statter

6 DATE OF BIRTH (month, day, and year) April 18 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 063

(b) General nature of industry, business, or establishment in which employed (or employer) Printer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Aaron Statter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Sarah Koerber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs. Statter (Address) 11 S. Broadway

15 MAY 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1922, to May 21, 1922,

that I last saw him alive on May 21, 1922,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar Terminal

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Athero-Sclerosis Cerebral.

(duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Examination of Body

(Signed) Harry Linden, M. D.

, 19 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rosedale Cem.	5/24/1922
20 UNDERTAKER	ADDRESS
David Sondheim	118 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 64543 HEALTH DEPARTMENT—CITY OF BALTIMORE 1002 D 64543

CERTIFICATE OF DEATH. 159

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N Bond ST., 3 WARD)

2-FULL NAME Chas. P. Fuller

(a) RESIDENCE NO. 520 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 706

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Chas Fuller

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Maime Holland

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Chas. Fuller

(Address) 520 N Bond St.

MAY 23 1922 ROBERT A. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15 - 1922, to May - 22, 1922, that I last saw h— alive on May - 22, 1922, and that death occurred, on the date stated above, at 10-15 p - m.

The CAUSE OF DEATH* was as follows:

Cardiac Dis - Valvular - Congenital

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Maude C Brooks, M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cem	May 23 1922
20 UNDERTAKER	ADDRESS
William Cook	506 E Monument

N. B.—WRITE plainly. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated correctly. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64544

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Madden

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 MAY 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to May 21, 1922.

that I last saw him alive on May 20, 1922,

and that death occurred, on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? APP-autopsy

(Signed) Clyde Mercer, M.D.

5/23/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 5/23 1922

20 UNDERTAKER Mrs. Maude Fink

ADDRESS 1335 W. Pratt St.

N. B.—Write plainly and be careful to be sure that all information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64545

CERTIFICATE OF DEATH.

107-003

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospital St., 15 WARD)

2-FULL NAME Robert Ferguson

(a) RESIDENCE NO. 2010 Ridgewood Ave St., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Robert Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Virginia Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Ferguson

(Address) 2010 Ridgewood Ave

15 Filed MAY 23 1922 19 ... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 22, 1922, that I last saw him alive on May 22, 1922, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Abscess of Lung

due to

Streptococcus & Spirochaeta

Vincent (duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Lab. findings

(Signed) Sinclair S. Parr, M. D.

..., 19 22 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL May 23 1922

20 UNDERTAKER William Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64546

D 64546

146

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 Harlem Ave. WARD 12)

2-FULL NAME Mamie Chambers

(a) RESIDENCE. (Usual place of abode) No. 2003 Harlem Ave. WARD.

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md

PARENTS

10 NAME OF FATHER D. C. Moody

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Jane Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant James Moody (Address) 2003 Harlem Ave

15 MAY 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to May 21, 1922, that I last saw he alive on May 21, 1922, and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis

Cold

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Confinement Child Birth (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? x

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Hall, M. D.

. 19 (Address) 1426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 23 1922
20 UNDERTAKER James L. Dennis	ADDRESS 1303 Greenmount

mation should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64547 HEALTH DEPARTMENT—CITY OF BALTIMORE 179 D 64547

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Wilkens Ave. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Frederick Hoffmeier

(a) RESIDENCE NO. 1722 Wilkens Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Hoffmeier

6 DATE OF BIRTH (month, day, and year) Jan. 6th 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor of 034

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery & Provision Store

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Hoffmeier

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Charles Soper

(Address) 1722 Wilkens Ave.

15 MAY 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13th, 1922, to May 21st, 1922, that I last saw him alive on May 20th, 1922, and that death occurred, on the date stated above, at 9.55 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? uremia and blood pressure test

(Signed) Chas Soper, M. D.

May 22, 22 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL May 24 1922

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Calvert St

N. B.—WHITE should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—1-10-21—M&T—1500 Blks.

D 64548

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-01 64548

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Hollins st. ST., 19 WARD)

2-FULL NAME Lorenz Rudolph Behlert

(a) RESIDENCE NO. 1719 Hollins St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 42 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Knapp

6 DATE OF BIRTH (month, day, and year) Dec. 2nd 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Builder)

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant L. L. K. Behlert

(Address) Halethorpe, Md.

15 Filed MAY 23 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 22 1922.

that I last saw h alive on May 21, 1922

and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos 5 ... ds.

CONTRIBUTORY (Secondary) age.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) John M. Evans M. D.

May 22nd, 19 22 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL May 25 19 22

20 UNDERTAKER Joseph B. Cook

ADDRESS 603 N. Bolton St

N. B.—Information should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64549 | 74-001 | D 64549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 Marriman St., 24 WARD)

2-FULL NAME Julia T. Coady

(a) RESIDENCE NO. 305 Marriman ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced

HUSBAND (or) WIFE Chas L. Coady

6 DATE OF BIRTH (month, day, and year) 1862 —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home [illegible] 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patk Cleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliz Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas L Coady

(Address) 305 Marriman Ave

15 Filed MAY 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20/22 19

17 I HEREBY CERTIFY, That I attended deceased from May 10/22, 19 ..., to May 20/22, 19 ..., that I last saw h[illegible] alive on May 20/22, 19 ..., and that death occurred, on the date stated above, at 5.30P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) Jas Hollomon, M. D.

5/23, 19 (Address) 1072 West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem

DATE OF BURIAL 5/24 19

20 UNDERTAKER J. F. Fahey & Sons

ADDRESS 311 Light St

N. B. [illegible] should be carefully supplied. AGE should be mation should be properly classified. Exact statement of occupa CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64550

D 64550

CERTIFICATE OF DEATH.

Registered No. C 171

1-PLACE OF DEATH

City of BALTIMORE: (No. Riverside Park. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William V. Maddox.

(Residence in Baltimore: No. 1625 Belt Ave. St.; 21 yrs., ---------- mos., ---------- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. Do not know. (Month) (Day) 1880 (Year)

7-AGE. 42 yrs. ---------- mos. ---------- ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Engineer D 3d
(b) General nature of industry, business, or establishment in which employed (or employer). B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country). Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, John Maddox.

11-BIRTHPLACE OF FATHER, (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER, Annie Dorn.

13-BIRTHPLACE OF MOTHER, (State or Country). Vermont.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Loretta R. Maddox. (wife)

(Address) 1625 Belt Ave.

15- Filed MAY 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide,
by cutting his throat with
a penknife. External Hemorrhage.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

May 22nd 1922. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem. DATE OF BURIAL. 5/24 1922

20-UNDERTAKER. J. F. Lahey & Sons ADDRESS 318 E. Lexington St.

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Surydan) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64551

CERTIFICATE OF DEATH.

188,001

D 64551

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Eutaw Ave ST.: 9 WARD)

2-FULL NAME Annette J. Mrs. Surydan

(a) RESIDENCE. NO. 825 Eutaw Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Surydan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Newark N J

12 MAIDEN NAME OF MOTHER Edith E Salsbury

13 BIRTHPLACE OF MOTHER (city or town) St Louis Mo.
(State or country)

14 Informant Henry Surydan
(Address) 825 Eutaw Ave grave

15 Filed MAY 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to May 22, 1922,

that I last saw her alive on May 20, 1922,

and that death occurred, on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia ODN

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H W Wheaton, M. D.

, 19 (Address) 4235 Yt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem 5-24 1922 DATE OF BURIAL

20 UNDERTAKER H. C. Branning & Son ADDRESS 517 N. Schroeder St

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Child also seen by Dr Summers & of the clinic also confirmed diagnosis. Could not determine whether or not any prior infection

Spec.—1-10-21—M&T—1500 Bks.

D 64552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64552

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 N Milton Ave ST., 6 WARD)

2-FULL NAME Amanda A Smith

(a) RESIDENCE No. 406 N Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Smith

6 DATE OF BIRTH (month, day, and year) Aug 12 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co.

PARENTS

10 NAME OF FATHER Caleb P Spicer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

12 MAIDEN NAME OF MOTHER Margaret Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Samuel L Smith

(Address)

15 Filed MAY 23 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20th, 1922, to May 22nd, 1922, that I last saw h[illegible] alive on May 22nd, 1922, and that death occurred, on the date stated above, at 2 10 Q m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. [illegible] mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell, M. D.

, 19 (Address) 156 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 24 1922

20 UNDERTAKER Robt L Turner Inc — ADDRESS 1402 N Broadway

Information should be carefully supplied. AGE should be given. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 64553 HEALTH DEPARTMENT--CITY OF BALTIMORE D 64553

CERTIFICATE OF DEATH

1 PLACE OF DEATH — Registered No. C 139

City of Baltimore (No. 132 W. 10th St. St.: 36 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs. Sallie B. Starkey

(Residence in Baltimore: No. 132 W. 10th St. St.: 57 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE, MARRIED WIDOWED OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: April 14, 1865 (Month) (Day) (Year)

7 AGE: 57 yrs. 1 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9 BIRTHPLACE (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry Brusstar.

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Brown.

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Raymond W. Starkey
(Address) 132 W. 10th St

15 Filed MAY 23 1922 H. Helm REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 22, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922, A.M. to May 22, 1922, P.M.
that I saw h[er] alive on May 22, 1922.
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Cardiac Asthma
Chronic Nephritis

(Duration) yrs. 1 mos. 3 ds

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. ds.

(Signed) E. E. McClanahan M. D.
May 22, 1922 (Address) 3508 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 25, 1922

20 UNDERTAKER: Geo. Fuhrman — ADDRESS: 1742 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64554 ~~D 64554~~

13-603-22

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bunting

(a) RESIDENCE. NO. R 505 Barclay St., WARD.
(Usual place of abode) Unknown.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Clarence Bunting

6 DATE OF BIRTH (month, day, and year) Dec 5, 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 1,037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER James Marks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Corbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAY 23 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

Cor. of Clarence D. Bunting via Baltimore Md.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922, to May 22, 1922, that I last saw her alive on May 22, 1922, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) 4 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urine + Blood exam

(Signed) E. Sanger Brown, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lecato, Va.	May 24, 1922

20 UNDERTAKER	ADDRESS
Wm Cook, 50 E.	Howard

mation should be carefully supplied, so that it may be properly classified. Exact information CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64555

100-04 64555

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 115 S Curley ST.: 1st WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Dimling

(a) RESIDENCE. No. 115 S. Curley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ford Dimling

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unk

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unk

14 Informant: William Dimling

(Address): 115 S. Curley St

15 MAY 23 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-20 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-14, 1922, to 5-20, 1922, that I last saw h[illegible] alive on 5-20, 1922, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Terminal (Broncho) Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

May 24, 1922 (Address) 1139 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Gen.	May 24 1922
20 UNDERTAKER	ADDRESS
Eschenauer Bros	1039 Hanover

mation should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64556

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S Wolfe ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Wisniewska

(a) RESIDENCE. No. 324 S. Wolfe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaw Zalenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Frome

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Andrew Wisniewski

(Address) 324 S. Wolfe St.

15 Filed MAY 23 1922 19 Robert F. Barlow, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 21st 1922, to May 22 1922, that I last saw h alive on May 22 1922, and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cedel V Bliley, M. D.

May 23 1922 (Address) 100 S. Patterson Park Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	May 24 1922
20 UNDERTAKER M. F. Sadowski	ADDRESS 905 S. Am

mation should be carefully supplied. ... should be properly classified. Exact statement ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Genco)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64557

CERTIFICATE OF DEATH.

101-001

D 64557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2221 E. Fayette ST.: 6 WARD)

2-FULL NAME Gaspare Genco

(a) RESIDENCE. NO. 2221 E. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Testudine

6 DATE OF BIRTH (month, day, and year): June 30-1889

7 AGE: 32 Years 10 Months 21 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Vincenzo Genco

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Antonina Nicosia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Vincenzo Genco 2221 E Fayette St.

15 Filed . . 19 Robert P. Harrison, Registrar

MAY 23 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to May 21, 1922 that I last saw him alive on May 21, 1922 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Lenarsno, M. D.

May 22 1922 (Address) 2211 Stiles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: 5/24 1922

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford

mation should be carefully supplied. Avoid abbreviations. Write plainly in ink. OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64558

CERTIFICATE OF DEATH.

90 D 64558

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Brandt

(Residence in Baltimore: No. St. Josephs Hospital St.: 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH Oct. 15-th ....., 1 .....
(Month) (Day) (Year)

7-AGE. 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Ham
(b) General nature of industry, business, or establishment in which employed (or employer)..... Work 800

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Brandt

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Brandt

(Address) 2641 Wilkens ave

15- Robert P. Harrison,

MAY 23 1922 ....., 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 3 1922, to May 20 1922, that I saw h.e.R alive on May 20 1922, and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

..... (Duration)..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

..... (Duration)..... 3 yrs. ..... mos. ..... ds.

(Signed) Herman H. Dorf M. D.

May 20, 1922 (Address) St. Josephs Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. ..... mos. ..... ds. In the State 44 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Maryland

Former or usual residence 2641 Wilkens ave.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, May 25, 1922

20-UNDERTAKER George F Ruth

ADDRESS 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64559

CERTIFICATE OF DEATH

D 64559

REGISTERED NO. 31

1-PLACE OF DEATH 948 N. Washington St

CITY OF BALTIMORE: (No.) ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James Slaech

(a) RESIDENCE NO. 948 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

Exact statement of the date of birth may be necessary later for correct registration. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Mary Slaech

6 DATE OF BIRTH (month, day, and year): November 16, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paperhanger 15 Y

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: James Slaech

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Wife

(Address): [illegible]

15 [illegible] 19

MAY 23 1922 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to May 23, 1922, that I last saw him alive on May 22, 1922, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) [illegible], M.D.

, 19 (Address) 447 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible]

DATE OF BURIAL: May 25 1922

UNDERTAKER: [illegible]

ADDRESS: 1909 Maryland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64560

CERTIFICATE OF DEATH.

D 64560

REGISTERED NO. 180-901 D 64560

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1714 Linden Ave ~~St.~~ 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Jameson

(a) RESIDENCE. NO. 1714 Linden Ave ~~St.~~ WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~: Fannie A Jameson

6 DATE OF BIRTH (month, day, and year): June 8th 1851

7 AGE: Years 71 Months Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steel Merchants

(b) General nature of industry, business, or establishment in which ~~employed~~ (or employer): Jameson McKenzie & Evans

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Andrew Jameson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Mary Timeous

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Judge Soper Baltimore Md

15 Filed ....., 19..... Registrar: Robert P. Harrison, Burial Permit Clerk.

MAY 23 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22d 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1922, to May 22d, 1922, that I last saw h~~im~~ alive on the May 22d, 1922, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary): General debility for years (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical examinati

(Signed) John I Pennington, M. D.

, 19 (Address) 1826 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: May 25 1922

20 UNDERTAKER: Henry W Jenkins & Sons Co — ADDRESS: Orchard Mc-Collob St

mation should be carefully supplied, so that it may be properly classified. Each question CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 64561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64561

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Wibber McCorkle

(Residence in Baltimore: No. 2031 W Lanvale St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Oct (Month) 19 (Day) 1919 (Year)

7-AGE. 2 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... off

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Geo McCorkle

11-BIRTHPLACE OF FATHER. (State or Country) North Carolina

12-MAIDEN NAME OF MOTHER. Mabel Lewis

13-BIRTHPLACE OF MOTHER. (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel McCorkle

(Address) 2031 W Lanvale St

15- MAY 23 1922 Robert P. Harrison, 192..... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest
Automobile accident

(Duration) .....yrs. .....mos. 4 hrs

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) James H Pinkerton M. D. (Coroner.)

May 23 1922 (Address) Jones Chapel

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos. 4 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2031 W Lanvale St

19-PLACE OF BURIAL OR REMOVAL. Charlotte N.C. DATE OF BURIAL. MAY 23 1922 19....

20-UNDERTAKER. Geo W Little ADDRESS 27 E Lexington St

Every item of information should be given, and should be properly classified. Exact statement of cause is necessary. To state CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64562

CERTIFICATE OF DEATH.

31 D 64562

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 775 W Saratoga St (Ward) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert A Abicht

(a) RESIDENCE. No. 775 W Saratoga St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Abicht

6 DATE OF BIRTH (month, day, and year) 6-26-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass worker

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas Abicht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Voigt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Maggie Abicht 775 W Saratoga St

15 Filed MAY 23 1922 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1. 1921, to May 22. 1922 that I last saw him alive on May 22. 1922 and that death occurred, on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) None —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) H C Spielmeyer M. D.

5/23/22 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL MAY 25 1922

20 UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64563

D 64563

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST. 28th (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Chrisman

(a) RESIDENCE. No. Mt Hope Retreat ST. 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., If of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Nora Chrisman

6 DATE OF BIRTH (month, day, and year) Jan 25- 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Adams Co Penna.

PARENTS

10 NAME OF FATHER Charles Chrisman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Adams Penna

12 MAIDEN NAME OF MOTHER Elizabeth Felty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) McCalls Penna

14 Informant (Address) Nurse, Mt Hope Retreat Mt Hope Balto Md.

MAY 23 1922

Registrar

Postal Permit clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 1922, to May 23rd, 1922, that I last saw him alive on May 22nd, 1922, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

over (duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Phobic Psychosis.

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Hanover Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

May 23, 1922 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Joseph Cemetery Hanover Pa	May 27 1922
UNDERTAKER	ADDRESS
Henry W. Offutt & Son	1952 W. Balto

mation should be carefully supplied, so that it may be properly classified. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF THE CAUSE OF DEATH is very important. See instructions on back of certificates.

D 64564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64564

CERTIFICATE OF DEATH.

REGISTERED No. C 165

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Franklin Sq. Hospital St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Herman J. Rochu

(Residence in Baltimore: No. 5225 Melvin Ave. Arlington St.; 44 yrs., 8 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Sept. 18, 1877 (Month) (Day) (Year)

7-AGE. 44 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Accountant 086
(b) General nature of industry, business, or establishment in which employed (or employer). Baugh Chemical Co

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. August Rochu

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Lena Mueller

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Minnie De Setta Rochu
(Address) 5225 Melvin Ave

15-
Filed....., 191.....
Robert P. Harrison,
Burial Permit Clerk. Registrar.

MAY 23 1922

N. B.—Every item of information should be carefully supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21st, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to by death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bi Chloride mercury Poisoning Suicidal
(Duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Acute Nephritis
(Duration) ..... yrs. ..... mos. 3 ds.
(Signed) James M Fenton M. D. (Coroner.)
May 23, 1922 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Franklin Sq Hos In the city of death ....yrs. 4 mos. ....ds. State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? 5225 Melvin ave Arlington
Former or usual residence 5225 Melvin ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	May 24, 1922
20-UNDERTAKER	ADDRESS
Mrs Mrs J. W. Teufel & Son	801 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64565

CERTIFICATE OF DEATH.

90 D 64565

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 573 Hanover ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Givins

(a) RESIDENCE. NO. 573 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fmal	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Givins

6 DATE OF BIRTH (month, day, and year) Feb 22-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress at home

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Smith (Address) 573 Hanover st

15 Filed MAY 23 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 19 22, to May 21, 19 22

that I last saw h[illegible] alive on May 20, 19 22

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. one mos. — ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) H. E. Link M. D

May 22 19 22 (Address) 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Baltimore Md. DATE OF BURIAL: May 24-22

20 UNDERTAKER: Chas. Alexander ADDRESS: 72 W. Lanvale

mation should be carefully supplied. Any omission CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64566

CERTIFICATE OF DEATH.

38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hos. ST., 15 WARD)

2-FULL NAME Douglas H. Dawson

(a) RESIDENCE NO. 2001 Dukeland ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary L. Valiant Dawson

6 DATE OF BIRTH (month, day, and year) April 10-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. American Ice Co

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Michaels Md

PARENTS

10 NAME OF FATHER Dr Jas Dawson

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Louise Hambleton

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mary L. Dawson (Address) 2001 Dukeland ave.

15 Filed ..... 19 ..... Registrar

23 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922 to May 23 1922.

that I last saw h[illegible] alive on May 22 1922

and that death occurred, on the date stated above, at 7-4 m.

The CAUSE OF DEATH* was as follows:

Spinal Syphilis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Decubitis Gangrene

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of April 15 22

Was there an autopsy? .....

What test confirmed diagnosis? Wassman

(Signed) Jno W Mayhew, M. D.

, 19 (Address) 204-6 Professional Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 25 1922

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1948 W. North ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64567

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532-N. Caroline ST.: 5 WARD)

2-FULL NAME Wesley Boyd

(a) RESIDENCE. NO. 532-N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. —

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (~~WIFE~~) Nellie Boyd

6 DATE OF BIRTH (month, day, and year) 9/1/1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	5	20	/

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilson N.C.

PARENTS

10 NAME OF FATHER Samuel Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Whitemore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Nellie Boyd
(Address) 532-N. Caroline St

15 5/23/1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 21, 1922, that I last saw h[illegible] alive on May 21, 1922 and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Burns, M. D.

May 22, 19 (Address) 722 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	5/24/22
20 UNDERTAKER E Walter Jackson	ADDRESS 623 E North Ave

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64568

58-091

D 64568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2831 Penna. Ave (St.) 13 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian R. Stitz

(a) RESIDENCE. No. 2831 Pennsylvania Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary Stitz

6 DATE OF BIRTH (month, day, and year): Nov 1, 1873

7 AGE: Years 48 Months 6 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot Co Md

PARENTS

10 NAME OF FATHER: John Stitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lena Berlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary Stitz 2831 Penna Av

15 Filed MAY 23 1922, 19—. Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAY 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to May 23, 1922, that I last saw h[er] alive on May 22, 10.30 P.M. 1922, and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertrophic Pneumon.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Full Blood Exam.

(Signed) Thos. Harlan Stark, M. D.

MAY 23 1922 (Address) 2731 Parkwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: MAY 27 1922

20 UNDERTAKER: Geo W Little

ADDRESS: 2700 Edmondson Av

MAY 23 1922

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64569

CERTIFICATE OF DEATH.

24 × 31

1-PLACE OF DEATH U.S.VETERANS' HOSP.#56-

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sonny Smith,

(a) RESIDENCE NO. U.S.Veterans' Hosp.#56 ST., WARD

(Usual place of abode) Ft.McHenry,Md.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) --- (State or country)

12 MAIDEN NAME OF MOTHER ----

13 BIRTHPLACE OF MOTHER (city or town) --- (State or country)

14 Informant Hospital Records

(Address) Ft.McHenry,Md.

15 Robert F. Harrison, Registrar

MAY 23 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 15, 19 22, to May 22, 1922,

that I last saw him alive on May 22, 1922,

and that death occurred, on the date stated above, at 6:22 p m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis, far adv. and active

(duration) - yrs. - mos - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? - Date of -

Was there an autopsy? No

What test confirmed diagnosis? Laboratory report

(Signed) M. A. Fiske M. D.

5/22/22 (Address) SURGEON, U.S.P.H.S. Ft.McHenry,Md. U.S.V.Hosp.#56

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asheville N. C.

DATE OF BURIAL May 23, 1922

20 UNDERTAKER J. Leinsor & Bro

ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 64570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.VETERANS' HOSP.#56,

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME STANLEY ZARZECKI,

(a) RESIDENCE NO. U.S.VETERANS' HOSP.#56, ST., WARD

(Usual place of abode) Ft.McHenry,Md. (Duryea,Pa.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant HOSPITAL RECORDS
(Address) U.S.V.Hosp.#56,Ft.McHenry,Md.

15 Robert F. Harrison,
Filed , 19
Registrar
Burial Permit Clerk.

MAY 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan.22, 1922, to May 20, 1922

that I last saw him alive on May 20, 1922,

and that death occurred, on the date stated above, at 10:20 p m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis,mod. advanced and active

- (duration) - yrs. mos - ds.

CONTRIBUTORY (Secondary) --

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? - Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Report

(Signed) M.X.S. [illegible], M. D.

5/20/22 (Address) SURGEON U.S.P.H.S. U.S.V.Hosp.#56,Ft.McHenry,Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wyoming Pa

DATE OF BURIAL May 24 1922

20 UNDERTAKER J. Lainer & Bro

ADDRESS 1827 E. Baltimore St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

105536
D 64571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1/3 D 64571

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Watkins

(a) RESIDENCE. NO. Covington, Va. ST., WARD. Covington Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brickmason

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Tully

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MAY 23 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922, to May 23, 1922, that I last saw h[illegible] alive on May 23, 1922, and that death occurred, on the date stated above, at 1[illegible] a m.

The CAUSE OF DEATH* was as follows:

Intestinal hemorrhage

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Myeletis - Lept. meningitis

(duration) 7 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 5, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Warfield M Feron, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Covington Va.	May 23 1922
20 UNDERTAKER	ADDRESS
William E. Schaeffer	816 Monument

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous — not luetic. Operation for mastoiditis
Cause of hemorrhage not known, sympathetic, probably new involvd. After careful inquiry no further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64572

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 19 Ward) 46

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Minnie Brown

(a) RESIDENCE. No. 202 N. Gilmor st. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Allen F. Brown

6 DATE OF BIRTH (month, day, and year): Aug. 8" 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wesminster, Maryland

PARENTS

10 NAME OF FATHER: Michael Sweetman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co. Maryland

12 MAIDEN NAME OF MOTHER: Anna Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Maryland

14 Informant (Address): Le Roy E. Brown, 202 N. Gilmor St.

15 MAY 24 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to May 23, 1922, that I last saw her alive on May 23, 1922, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary tuberculosis

(duration) 13 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Frances L. Babaglieri M. D.

5-23-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cem (Hampden)	May 25, 1922
20 UNDERTAKER: Joseph B. Cook	ADDRESS: 1023 N. Balto St.

N. B.—[illegible] mation should be carefully supplied. AGE should be [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64573

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2036 S. Charles St. 23 WARD)

2-FULL NAME Philemon A. Ramsay.

(a) RESIDENCE. NO. 2036 S. Charles st. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9 1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Journal Joural.

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Ramsay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anne Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Alice Ramsay
(Address) 2036 S. Charles st.

15 Filed MAY 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1922, to May 22, 1922,

that I last saw h~~im~~ alive on May 22, 1922,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. Campbell M. D.

May 23, 1922 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Western Cemetary Co. May 25 1922

20 UNDERTAKER — ADDRESS

Mrs J. L. Evans & Son 1425 E. Chase

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64574

CERTIFICATE OF DEATH.

159-00 V

D 64574

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1551 Ensor St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert William Campbell

(Residence in Baltimore: No. 1551 Ensor St St.; ..... yrs., ... mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 18 (Day), 1922. (Year)

7-AGE, ... yrs. ..... mos. 6 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, William Randall Campbell

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Agnes Longridge

13-BIRTHPLACE OF MOTHER (State or Country), West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William R Campbell

(Address) 1551 Ensor St

15- FILED MAY 24 1922 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23 (Day), 1922. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 18 1922, to May 23 1922, that I saw him alive on May 23 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer Gill Hall M. D.

May 23, 1922 (Address) 1617 E Northern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem'y — DATE OF BURIAL, May 24, 1922

20-UNDERTAKER Wm J. Evans Inc — ADDRESS 1428 Park Ave

N. B.—Every item of information should be carefully supplied. Please have CAUSE OF DEATH classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64575

99-902

D 64575

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1416 Colvin St. ; ST. 5 or (Parkinson) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Georgiana M. Parkinson (or Parkson)

(Residence in Baltimore: No. 1416 Colvin St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col.	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1 ..... (Year)

7-AGE	If LESS than 1 day,
..... yrs. 9 mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... —
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Ohio

9-BIRTHPLACE (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Dan. Parkinson

11-BIRTHPLACE OF FATHER (State or Country). Jamaica W. I.

12-MAIDEN NAME OF MOTHER B. Corbin

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. Parkinson

(Address) 1416 Colvin

15- Filed MAY 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk and Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May ..... (Month) 22 ..... (Day), 1922 ..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Hem Colitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

May 23, 1922 (Address) 1659 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, May 24, 1922

20-UNDERTAKER Mrs J. G. Locke

ADDRESS 1302 Jeffs

N.B.—Every item of information must be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

c.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64576

CERTIFICATE OF DEATH.

X 90 D 64576

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Millington ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H. Chester

(Residence in Baltimore: No. 1708 Millington St.; ..... yrs., 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Don't know ..... (Month) ..... (Day) 1858 (Year)

7-AGE, 64 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Dorchester Co Md

PARENTS.

10-NAME OF FATHER, Wm Chester

11-BIRTHPLACE OF FATHER (State or Country), Africa Island

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. J. Chester (Son)

(Address) # 324 N. Spring St.

15-

Filed MAY 24 1922 ROBERT N. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922, to May 22 1922, that I saw h alive on May 22 1922, and that death occurred, on the date stated above, at 7 10 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

5/23/22, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Dorchester Co Md

19-PLACE OF BURIAL OR REMOVAL, Samuel Sem. DATE OF BURIAL, 5/25/22 191...

20-UNDERTAKER James Jr. Skinner ADDRESS 852 E. Fred st

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

Spec.-1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64577

CERTIFICATE OF DEATH.

179 D 64577

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Upland Farm Old Fred. Rd ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Mary C Bargar

(a) RESIDENCE NO. Upland Farm Old Frederick Rd, Baltimore ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Bargar

6 DATE OF BIRTH (month, day, and year) Sept 4 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	59	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER Geo. Metzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Elizabeth Ziegler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa

14 Informant William Bargar (Address) Upland Farm

15 MAY 24 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1915, to May 23, 1922, that I last saw h[illegible] alive on May 22, 1922 and that death occurred, on the date stated above, at 3:10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Paralysis and apoplexy

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hattie E. Tuckman M. D.

May 25, 1922 (Address) 2002 N Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	5/25 1922

20 UNDERTAKER	ADDRESS
Wm Cook	502 E. North ave

mation should be carefully supplied. AGE should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Schemma

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

74 D 64578

D 64578

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 W Pratt ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman H Schemma

(a) RESIDENCE. No. 1317 W Pratt ST. 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Jan 10 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Schemma

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Amelia Schemma

(Address) 1317 W Pratt St

15 Filed MAY 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from 4/28, 1922, to 5/22, 1922, that I last saw h. alive on 5/20/22, 19, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage, (Apoplexy)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. H. Wessels, M. D.

5/23, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: May 25 19 22

20 UNDERTAKER: John J Fields

ADDRESS: 1200 W Fayette

MAKE STATEMENTS PERTAINING TO EACH ITEM. Information should be carefully supplied so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

Frances Sleadman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64579

CERTIFICATE OF DEATH.

X 148 D 64579

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Francis Sleadman ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 1535 Barclay St.

(Residence in Baltimore: No. 1535 Barclay St. Baltimore St.; — yrs. 11 mos. ds.)

Residence in Balt— 11 months

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 21 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Servant. 076
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Andrew Sleadman

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Marie Boldon

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Marie Boldon

(Address) 15-35- Barckley st Baltimore

15- MAY 24 1922 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to May 22, 1922, that I saw h[illegible] alive on May 22 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as followa:

9780

Acute Interstitial Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Hugh Forsythe M. D.

May 23, 1922. (Address) 424 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence South Carolina

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery

DATE OF BURIAL, May 24....., 1922.

20-UNDERTAKER Wm Robert-A Elliott

ADDRESS 1725 Ashland Ave

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Each important. See instructions on back of certificate.

Indirectly due to pregnancy. Child delivered. Mother abnormal condition called as Dr Tony the could determine if only illness 2 days

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 64580

D 64580

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Little Sisters of the Poor ST.: 10 WARD)

2-FULL NAME Peter Foertsch

(a) RESIDENCE. NO. Preston Valley Rd. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Stackgardt

6 DATE OF BIRTH (month, day, and year) Oct 9th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Peter Foertsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sister Florence

(Address) Little Sisters of the Poor.

15 Filed MAY 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 , to , 19 , that I last saw h alive on May 20, 1922, and that death occurred, on the date stated above, at 6½ P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner M. D

May 23, 1922 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	May 25th 1922
20 UNDERTAKER	ADDRESS
Leo G. Cook	North Howard

mation should be carefully supplied. Also answer all questions. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Knight

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64581

CERTIFICATE OF DEATH.

D 64581

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 727 Baker ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Fannie Knight

(a) RESIDENCE. NO. 727 Baker ST., ...WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 19, 11

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER William Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Susie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Susie Knight

(Address) 727 Baker St

15 MAY 24 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21 19 22

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 19 22, to 5/22, 19 22, that I last saw her alive on 5/21, 19 22, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if, not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkett, M. D.

, 19 (Address) 2139 Dk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 5/24/22

20 UNDERTAKER Robert E. Weller

ADDRESS 1106 Oakland

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64582

CERTIFICATE OF DEATH.

91 D 64582

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospt ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel T Moore. (Moore)

(a) RESIDENCE. No. 5037 E Eutaw Pl ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life V mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widr

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 18-33

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ret Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 04 5

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Abm Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) NY

12 MAIDEN NAME OF MOTHER Martha Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs M. Kinnersley

(Address) 2616 E. Hoffman

15 MAY 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/22

17 I HEREBY CERTIFY, That I attended deceased from 5/10/22, 19..., to 5/22/22, 19..., that I last saw him alive on 5/22/22, 19..., and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Senility & Arteriosclerosis

(duration) ... yrs. — mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? —

What test confirmed diagnosis? Clinical findings

(Signed) Jno Crampton, M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leiden Pk

DATE OF BURIAL 5/25 19 22

20 UNDERTAKER Phillip Herring

ADDRESS 204 Oldham

N. B.—MARRIED WOMEN should be stated by their CHRISTIAN NAMES. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated by their CHRISTIAN NAMES

Spec.—1-10-21—M&T—1500 Bks.

D 64583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO. .....

CITY OF BALTIMORE: (NO. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Cogar

(a) RESIDENCE NO. Church Home & Infr., WARD Webster Springs W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

Exact statement of OCCUPATION should be carefully supplied. AGE should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elihu P. Cogar

6 DATE OF BIRTH (month, day, and year): Sept - 1861

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Va

PARENTS

10 NAME OF FATHER: Matthias Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Eva Cogar Webster Springs W Va

15 Filed MAY 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 20 19 22 to May 22 19 22,

that I last saw her alive on May 22, 19 22,

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Cholecystitis, Cholelithiasis

Duodenal Ulcer, Multiple

(duration) ✓ yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Peritonitis, General

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? (?

Did an operation precede death? yes Date of May 20 22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Caytano Lucchese M.D.

19 (Address) Church Home & Infr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Webster Springs W Va

DATE OF BURIAL: 5/24/22

UNDERTAKER: Chas. Evans & Son

ADDRESS: 118 W Mt Royal Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 64584 — PLACE OF DEATH — REGISTERED NO. C 51 D 64584

CITY OF BALTIMORE (No. 3009 Littleton Road St. 15 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emelia J. Pattuson

(Residence in Baltimore: No. 3009 Littleton Road St.: 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: April (Month) 12 (Day), 1854 (Year)

7-AGE: 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): New York N. Y.

PARENTS

10-NAME OF FATHER: Jacob B. Stonebreaker

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Elizabeth Wilson

13-BIRTHPLACE OF MOTHER (State or country): New York N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Blanch S. Pattuson

(Address) 3009 Littleton Road

15

DATE: MAY 24 1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May 23rd (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1. 1922. to. May 23 1922.
that I saw her alive on May 22 1922.
and that death occurred, on the date stated above, at 2. A. m.
The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Myocarditis.

(Duration) yrs. 2 mos. ds.

(Signed) Herbert C Blake M. D.
May 23, 1922 (Address) 1014 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: May 25 1922

20-UNDERTAKER: Wilbur W Shriver — ADDRESS: 1018 Edmondson Ave.

N. B.-Every item of information should be answered; if none, state so. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64585

CERTIFICATE OF DEATH.

D 64585

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 West Lanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Stockhausen

(a) RESIDENCE. No. 1024 West Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Karl W. Stockhausen

6 DATE OF BIRTH (month, day, and year): Dec. 11, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	89	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Louis Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Justine Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas. L. Stockhausen
(Address): 1024 W. Lanvale Street

15 Filed Robert P. Harrison, Registrar

7 24 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1921, to May 22, 1922, that I last saw h.e alive on May 22, 1922, and that death occurred, on the date stated above, at 8 55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Fracture of Femur at hip 9/17/22-5/23

(duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary): Hemorrhage from stomach 1 hour

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) John S. Bishop, M. D.

5/23, 1922 (Address) 930 N. Calvert st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	5/25, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64586

CERTIFICATE OF DEATH.

D 64586

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 3800 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Murtagh (Vel Mullaugh)

(a) RESIDENCE. No. Mt Hope Retreat ST., 28th WARD. Nativity-Unknown

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 50 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt	74	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat Md.

15 Filed . 19 ROBERT J. HARRISON, Registrar

Burial Permit Clerk.

24 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17

I HEREBY CERTIFY, That I attended deceased from May 7th 1890 , to May 23rd , 1922.

that I last saw her alive on May 22nd , 1922

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Terminal Dementia Post Cho mania - 50 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore (?)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

May 23. 1922 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	May 25 1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODS, [illegible])

ADDRESS [illegible] BALTIMORE AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64587

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5232 Reisterstown Road ST.: 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Sommerman

(a) RESIDENCE. No. 5232 Reisterstown Road ST., 28th WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? 63 yrs. 4 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredericka Sommerman

6 DATE OF BIRTH (month, day, and year) Jan. 15-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler 038

(b) General nature of industry, business, or establishment in which employed (or employer) Jewelry Mfg.

(c) Name of employer Fred. Gruebel

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Sommerman

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine Schmidt

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Germany

14 Informant Mrs Fredericka Sommerman (Wife)

(Address) 5232 Reisterstown Road

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Y 24 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/15, 1922, to 5/23, 1922, that I last saw him alive on 5/22/, 1922, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs.? mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) Henry Russell, M. D.

, 19 (Address) 3902 Groveland Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 25 22

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Secretary)

ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64588

D 64588

CERTIFICATE OF DEATH.

REGISTERED NO. 100 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Riggs ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest H. Haynes

(a) RESIDENCE NO. 2700 Reggs ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Mary G. Haines

6 DATE OF BIRTH (month, day, and year) Dec 6, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Life Insurance

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Keefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mary G. Haines 2700 Reggs ave

15 [illegible] Robert P. [illegible] Registrar

4 24 1922

Deputy Register Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1922

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 22, 1922, that I last saw him alive on May 22, 1922, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M Bauman Kind, M. D.

5/22, 1922 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: May 25, 1922

20 UNDERTAKER: Perkins & Pinkler — ADDRESS: 737 Eager

mation should be carefully supplied, so that it may be properly classified. Exact statement of disease CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64589

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Baker

(a) RESIDENCE NO. Unknown ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 MAY 24 1922, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from May 20, 19 22. to May 24, 19 22.

that I last saw him alive on May 24, 19 22.

and that death occurred, on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

5/24/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hyattsville Md. DATE OF BURIAL May 25 19 22

20 UNDERTAKER Wm. J. Tichenor Sons ADDRESS North Capitol

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE or CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64590 D 64590

CERTIFICATE OF DEATH.

185

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 E. Oliver St.: 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Evans

(a) RESIDENCE. NO. 1512 E. Oliver ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22nd 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Busack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Carrie Becker

(Address) 1616 N Port St

MAY 24 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21. 1922

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1922, to May 21, 1922; that I last saw h[illegible] alive on [illegible], 1922, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

I (a) Fracture of femur near hip, Senile Pneumonia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Right hemiplegia

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H Hartman, M. D.

May 22. 1922 (Address) 2214 Mayfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltoiem

DATE OF BURIAL May 25th 1922

20 UNDERTAKER Leo G. Cook

ADDRESS North Ave

USE OF DEATH in plain terms, so that it may be properly classified. Blank ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64591

101-001

D 64591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Thelma Reubert

(a) RESIDENCE NO. 1733 N. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 8, 1916

7 AGE — Years: 5 | Months: 9 | Days: 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Reubert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Minnie Barrack

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mercy Hospital Ward

15 Filed , 19 Registrar

Robert F. Harrison,

Burial Permit Clerk.

24 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922 to May 24, 1922

that I last saw her alive on May 24, 1922

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Peritonitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Pneumonia & Bronchitis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of May 6 1922

Was there an autopsy? no

What test confirmed diagnosis? Symptoms, Physical Signs & Bacteriological Findings

(Signed) John J. Crum M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: May 26 1922

20 UNDERTAKER: Mr. & Mrs. J. W. Teufel & Son

ADDRESS: 801 W. Fayette

mation should be carefully written, so that it may be properly classified. Exact statement of disease CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar pneumonia.

D 64592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64592

CERTIFICATE OF DEATH.

4X 188-003

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Marcy Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William R. Marshall

(Residence in Baltimore: No. Sykesville Carroll Co. St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 69 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Minister
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Wm Marshall

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER L. I Lavern

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. R. Marshall

(Address) Sykesville

15-

Filed ....Robert P. Harrison, 191.....

Registrar.

2 4 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Fract Skull

Struck by automobile

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

1/2 hr (Duration).....yrs.....mos.....ds.

(Signed) M. Riley M. D. (Coroner.)

May 24, 1922 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. State few months or the.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Sykesville Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Romney, W. Va	5/26 1922
20-UNDERTAKER	ADDRESS
Jas. K. Weer	Sykesville Md.

Every item of information above must be given. Supply missing items, if any. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64593

CERTIFICATE OF DEATH.

D 64593

REGISTERED NO. 14 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Druid Hill Ave ST.: 14 WARD)

2-FULL NAME Maggie Copeland

(a) RESIDENCE. No. 1922 Druid Hill Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	married

5a If married, widowed, or divorced (or) WIFE of Thaddeus Copeland

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Petersburg Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thaddeus Copeland (Address) 1922 Druid Hill Ave

15 Filed MAY 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 23, 1922, that I last saw h alive on May 23, 1922, and that death occurred, on the date stated above, at 1 1/2 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (duration) yrs. mos. 3 hrs.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

5/24, 1922 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	5/24/22 19
20 UNDERTAKER	ADDRESS
Theodore White	113 S Wolfe St

mation should be carefully supplied. Also answer CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64594 003 D 64594

D 64594

CERTIFICATE OF DEATH.

REGISTERED No. C 159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1809 N Pulaski St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Phyllis McAllister

(Residence in Baltimore: No. 1809 N Pulaski St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, May (Month) 19 (Day), 1922 (Year)

7-AGE. ....yrs. ....mos. 4 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 000
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Charles James McAllister

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Margaret Elsie Rapp

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles J. McAllister

(Address) 1809 N. Pulaski St.

15- Filed MAY 25 1922, 191... ROBERT B. KRAUTER, Registrar. Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 24 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1922, to May 24 1922, that I saw h Ex alive on May 23 1922, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Imperfect development

(Duration) ....yrs. ....mos. 4 da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....da.

(Signed) W. F. Leech M. D.

May 24, 191 2 (Address) 118 N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, May 26 1922

20-UNDERTAKER Martin Funeral Home

ADDRESS 2320 W North Ave

Spec.—1-10-21—M&T—1500 Bks.

Vieweg

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64595

CERTIFICATE OF DEATH.

44 D 64595

1-PLACE OF DEATH Church Home Hosp

CITY OF BALTIMORE: (No. Broadway & Fairmount ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Vilwig.

(a) RESIDENCE No. 1337 N. Patterson Park Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Vieweg.

6 DATE OF BIRTH (month, day, and year): Mar 16-1863

7 AGE: Years: 59 | Months: 2 | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Stephan
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Marie T. Vogel
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Step Son Vieweg
(Address) 1337 N Pat Ave

15 Filed MAY 25 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/11/, 1922, to 5/23/, 1922, that I last saw h[illegible] alive on 5/23/22, 19..., and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis
Stomach - Omentum, Ascites

(duration) T yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Terminal Pneumonia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) M. J. Maguire, M. D.

, 19 (Address) 1 E Lex

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery
DATE OF BURIAL: May 26 22

20 UNDERTAKER: J Ellrick
ADDRESS: 2008 Aisquith

mation should be entirely supplied. Note.—It is important that it may be properly classified. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Muckley.

64596

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 64596

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL St.; 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Muckley

(a) RESIDENCE. No. 1038 E. Monument St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17th 1922

7 AGE — Years; 4 Months; 7 Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Beverly Muckley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Margret Dickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAY 25 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1922, to May 23, 1922, that I last saw him alive on May 23, 1922, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Syphilis, Congenital

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diarrhea - not dysentery

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasn't

(Signed) T B Gay, M. D.

, 19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: May 25th 1922

20 UNDERTAKER: Joseph A Farrell — ADDRESS: 581, Mission

Burial Permit Issued

Information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION in very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1009 Bks.

D 64597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001
16
D 64597

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 138 W Cross St., 23 WARD)

2-FULL NAME Infant of Mr & Mrs Wm L. Stone

(a) RESIDENCE. No. 138 W. Cross St., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 24 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Butts Md.

PARENTS

10 NAME OF FATHER Wm L. Stone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Butts Md.

12 MAIDEN NAME OF MOTHER Alice L Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Butts Md.

14 Informant Wm L. Stone (Address) 138 W Cross St

15 MAY 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to May 24, 1922, that I last saw h[illegible] alive on May 24, 1922, and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

I

Premature Birth

(Mrs Wm L Stone)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ephamotion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H E Campbell M. D.

May 24 1922 (Address) 1644 Harwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Conn	May 24th 1922
20 UNDERTAKER E Schloman & Son	ADDRESS 1034 Monroe St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64598

CERTIFICATE OF DEATH.

1431

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2014 Brunt St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Joseph H. Brown

(Residence in Baltimore: No. 2014 Brunt St.; 30 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH. about (Month) (Day) 1872 (Year)

7-AGE. 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer). 006

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Walter Brown

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Charlotte Bell

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jos. H. Brown

(Address) 2014 Brunt St.

15- MAY 25 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 24 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Pulmonary Tuberculosis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

May 24 1922 (Address) 202 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn DATE OF BURIAL. May 27th 1922

20-UNDERTAKER. Samuel L. Wright ADDRESS 664 W. Pratt

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 64599 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 152 D 64599

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur J. Stritch

(a) RESIDENCE NO. 1111 Battery ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Stritch

6 DATE OF BIRTH (month, day, and year) July 9 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	47	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police officer

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Stritch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Maher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Stritch (Address) 1111 Battery ave.

15 Filed MAY 25 1922 ROBERT A. KRAUTER, Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28th, 1922, to May 23, 1922.

that I last saw him alive on May 23, 1922,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Carbuncle

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of May 23/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B. Cook, M. D.

1922 (Address) 1203 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL May 26 1922

20 UNDERTAKER Fred. A. Krauer & Son. ADDRESS 703 Hanover St

Wm. L. Woolford

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64600

CERTIFICATE OF DEATH.

90D 64600

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 23 WARD)

2-FULL NAME W. L. Woolford

(Residence in Baltimore: No. 126 W. Randall St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, — (Month) — (Day) 186- (Year)

7-AGE: 60 yrs. mos. ds.

If LESS than 1 da ....hrs. or....mi:

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): G.F.

9-BIRTHPLACE (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: W Dorf Russ

11-BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Zenkenson

13-BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W. L. Woolford

(Address) 126 W. Randall St

MAY 25 1922 Filed ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Valvular Heart Disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (Duration) yrs. mos. ds.

(Signed) M. Riley M. D. (Coroner)

May 23 1922 (Address) 1059 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ten hrs yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Bluff Annapolis Cem Md — DATE OF BURIAL, May 25, 1922

20-UNDERTAKER F. A. Frances Son — ADDRESS 139 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64601

CERTIFICATE OF DEATH.

13 | D 64601

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 246 Eutaw St. (ST.) W. Franklin (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Casey

(a) RESIDENCE. No. 246 Eutaw St. (ST.) W. Franklin WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md

PARENTS

10 NAME OF FATHER Blake Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co Md

12 MAIDEN NAME OF MOTHER Emma Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co Md

14 Informant (Address) Blakes Casey 246 Eutaw St

15 Filed MAY 25 1922 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/19/ 1922, to 5/22/ 1922, that I last saw h[illegible] alive on 5/19/ 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T-B

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test (confirmed diagnosis)? —

(Signed) J. S. Hawkins, M. D.

5/23/ 1922 (Address) 1216 D. St. Nw.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	May 25 1922
20 UNDERTAKER Thos. Scott Hooper	ADDRESS 406 W. Conway

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64602 D 64602

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 N. Payson ST., 16 WARD)

2-FULL NAME Edward Milton Conner

(a) RESIDENCE NO. 801 N Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth M Hunt

6 DATE OF BIRTH (month, day, and year) Oct 6/60

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	7	18	

8 OCCUPATION OF DECEASED 052

(a) Trade, profession or particular kind of work Decorator & Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chambers & Co.

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Mc Conner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Leroy Conner (Address) 801 N Payson St

15 Filed MAY 25 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1922 to May 24 1922, that I last saw him alive on May 24 1922, and that death occurred, on the date stated above, at 7 20 a m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos One ds.

CONTRIBUTORY (Secondary) Shock & failing Heart 16 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) E. J. Smith M. D.

5/24 1922 (Address) 1608 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL May 26 1922

20 UNDERTAKER George J. Smith ADDRESS 1000 25 Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43D 64603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) ... ST., ... WARD)

2-FULL NAME Frank Scheurich.

(a) RESIDENCE NO. 1739 N. Chester ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced HUSBAND of Barbara Scheurich

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62.	5	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wheelwright.

(b) General nature of Industry, business, or establishment in which employed (or employer): 007

(c) Name of employer: Germany.

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER August Scheurich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Catherine Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Barbara Scheurich (Address) 1739 N. Chester St

15 MAY 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY That I attended deceased from May 15, 1922 to May 23, 1922.

That I last saw him alive on May 23, 1922

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Carcinoma - Larynx

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Hosp. Date of May 23, 1922.

Did an operation precede death? Yes.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E. C. Norris, M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: May 26 1922

20 UNDERTAKER: Chas J Turner Sons

ADDRESS: 14 & 22 N Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Particular attention is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hutton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64604

CERTIFICATE OF DEATH.

32 D 64604

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 N. Durham ST.: 7 WARD)

2-FULL NAME Joseph C. Hutton

(a) RESIDENCE. No. 1020 N. Durham ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Fannie V Hutton

6 DATE OF BIRTH (month, day, and year) 12-8-99

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thos V Hutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis, Md

12 MAIDEN NAME OF MOTHER Lotta Hawk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ernest Hutton

(Address) 1020 N. Durham

15 [illegible] Registrar

ROBERT R. KRAUTER
Burial Permit Clerk.

MAY 25 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 23/5/1922

17 I HEREBY CERTIFY, That I attended deceased from 16/4/1922 to 23/5/1922

that I last saw him alive on 22/5/1922

and that death occurred, on the date stated above, at 5.55 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) One D mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion, etc

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I don't know.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Dr Mayfield Boyle M. D.

23/5/1922 (Address) 412 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	May 25 1922
20 UNDERTAKER	ADDRESS
Chas H Grace Son	1403 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64605

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N Carlton ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Smith

(a) RESIDENCE NO. 126 N Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'e

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 31, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inf

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Williams Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Estella Sugars

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Estella Smith

(Address) 126 N. Carlton

15 Filed MAY 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/23/ 1922

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1922, to May 23, 1922, that I last saw her alive on May 22, 1922, and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Catarrhal Bronchitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Howell M. D.

5/25/ 1922 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL 5/26/22 19

20 UNDERTAKER: Samuel M. Chase-son

ADDRESS 1400 Monroe St

IMPORTANT. Please write DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64606

D 64606

CERTIFICATE OF DEATH.

74-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Barrett Walker ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 407 N Pine St

(Residence in Baltimore: No. 407 N Pine St.; 74 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1850 (Year)

7-AGE, 72 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Walker

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Hannah Walker

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Walker

(Address) 407 Pine St

15- MAY 25 1922 Filed....., 191... ROBERT R. KRAUTER Registrar.

Burial Permit Cl...

CAUSE OF DEATH in plain terms, if unusual, important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1922, to May 22 1922, that I saw him alive on May 21st 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary) Hemorrhage of the Brain

(Duration) yrs. mos. 10 ds.

(Signed) Frank R Lyman M. D.

May 23 1922 (Address) 322 N Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, May 23 1922

20-UNDERTAKER Samuel Hemsley ADDRESS 578 N Eden

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64607

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D-64607

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Howery

(a) RESIDENCE. NO. 420 N. Milton Ave ST.— WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 23 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Howery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Carington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAY 25 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1922, to May 24 1922, that I last saw h[illegible] alive on May 24, 1922, and that death occurred, on the date stated above, at 2 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute yellow atrophy of liver 00 00

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Amphetamine poisoning

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Boarding

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. Sidney Burwell, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lutheran Cem. Md	May 25 22 19
20 UNDERTAKER Robt Bruner Inc	ADDRESS 1 W. Broadway

137 CAUSE OF DEATH in plain terms, so that it may be understood. ATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Septic Infection

Spec.—1-10-21—M&T—1500 Bks.

D 64608 HEALTH DEPARTMENT—CITY OF BALTIMORE 64608

K 153

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Day

(a) RESIDENCE NO. ..... Bowie Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1921

7 AGE — Years: 1 — Months: 3 — Days: 5 — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Ellis Day

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Phelps

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Mercy Hospital Records (Address) .....

15 Filed MAY 25 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to May 24, 1922

that I last saw her alive on May 24, 1922

and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis

(duration) ..... yrs. 1 mos. 7 ds.

CONTRIBUTORY Broncho Pneumonia & Influenza

(Secondary) ..... (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5/12/22

Was there an autopsy? no

What test confirmed diagnosis? Finding Streptococcus Hemolyticus in Pus

(Signed) John J. Gordon, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Md — DATE OF BURIAL: May 27 19

UNDERTAKER: H. Staley — ADDRESS: Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. (NAME OF DISEASE MAY NOT BE SUFFICIENT.) See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pyogenic origin.
Not tuberculous. Not traumatic.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64609 D 64609

CERTIFICATE OF DEATH.

115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie M. Becker

(a) RESIDENCE. No. 1131 Cross ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Wilbur C Becker

6 DATE OF BIRTH (month, day, and year): Feb 18 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Charles J. Fleury

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York.

12 MAIDEN NAME OF MOTHER: Margaret Atz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: W. Clive C Becker
(Address) 1131 Cross St

15 FILED MAY 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to May 24, 1922, that I last saw her alive on May 24, 1922, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:-

Adeno-Carcinoma of Peritoneum producing Intestinal Obstruction

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Toxemia Cardiac failure (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? 1131 Cross St

Did an operation precede death? Yes Date of May 5. 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Whitehead, M. D.

. 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: May 27 1922

20 UNDERTAKER: Geo Leimbach & Son — ADDRESS: 647 W Baltimore

mation should be carefully supplied, so that it may be properly classified. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 64610

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto Gen Hospital (WARD)

2-FULL NAME Mrs Anna Neumann

(a) RESIDENCE NO. 626 S Wolfe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Neumann

6 DATE OF BIRTH (month, day, and year) Oct 22, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Henry.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Amal Hinton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Albert F. Goos.
(Address) 626 S Wolfe ste.

15 Filed MAY 25 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to May 23, 1922, that I last saw her alive on May 23, 1922, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of uterus with metastasis to the liver.

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intraabdominal hemorrhage (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Joseph Pokorny M. D.

, 19 (Address) South Balto Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	May 26 1922
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BURIAL must be entered. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64611

CERTIFICATE OF DEATH.

100 001 D 64611

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Green ST. (or) (WARD) 16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Brunner

(a) RESIDENCE. NO. 3409 E. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white.	married

5a If married, widowed, or divorced HUSBAND of Anna Brunner

6 DATE OF BIRTH (month, day, and year) April 18, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 years	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph F Brunner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp Records (Address)

15 Filed MAY 25 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24 1922

17

I HEREBY CERTIFY, That I attended deceased from 5-23, 1922 to 5-24, 1922

that I last saw him alive on 5-24, 1922

and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cholecystitis, Cholemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Clinical findings

What test confirmed diagnosis?

(Signed) R D Tyler, M. D.

, 19 (Address) Lombard & Green Sts University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 27 22
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Pleasant St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact must be complete. TION is very important. See instructions on back of certificates.

D 64612 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward) 23 1875

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Chester Friedman.

(Residence in Baltimore: No. 1506 S. Charles St. St.; yrs. 2 mos. 8 ds. 24)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widow or Divorced, (Write the word.)
Male.	White.	Single

6-DATE OF BIRTH. August 30th. 1919. 1.....
(Month) (Day) (Year)

7-AGE. 2 yrs. 8 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Harry J. Friedman.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Mina H. Weinstein.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry J. Friedman. (father)

(Address) 1506 S. Charles St.

15- Robert P. Harrison, 192 Registrar.

5 25 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 24th. 1922. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.....
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or Inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in the abdomen. accidentally shot while playing with a pistol.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto H. Reinhardt M. D.
(Coroner)

May 25th 1922. (Address) 10 W. Chas. St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
1506 S. Charles St. May 23rd. 1922.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Pikesville Russell	May 25 1922
20-UNDERTAKER.	ADDRESS
~~Catz~~ Jack Levin	1439 Park Ave

state CAUSE OF DEATH in plain terms. Indefinite answers are not sufficient. Omissions will be investigated, as it is very important. See instructions on back of certificate.

Bosc.—6-9-19—H. P. Co.—1000 Bks.

D 64613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64613

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Haspital ST.: 20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry H Johannes

(a) RESIDENCE. No. 5 St Dorman ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? ——— yrs ——— mos. ——— ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Johannes.

6 DATE OF BIRTH (month, day, and year) (1862 Jan 3)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler -

(b) General nature of industry, business, or establishment in which employed (or employer) 038

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Martin J. Johannes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie B. Benninga 5/22 1922

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Carl Johannes

(Address) 5 St Dorman ave

15 Filed 25 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to May 22, 1922,

that I last saw him alive on May 22, 1922,

and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Primal Arterio-sclerosis -
Chronic nephritis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) K. B. Jones, M. D.

(Address) University Haspital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL May 26 1922

20 UNDERTAKER E. B. Thesplet ADDRESS 2236 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

D 64614 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Inf — REGISTERED NO. 60

CITY OF BALTIMORE: (No. Broadways Fairmt ST., 27 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss. Maude Schwatka

(a) RESIDENCE NO. 519 York Rd: ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15-1904

7 AGE Years 17 Months Days 9 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Myers. Eng

PARENTS

10 NAME OF FATHER Doctor C. F. Schwatka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Alice Gladmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Doctor C. F. Schwatka (Address) Crisfield Maryland

15 1922 Robert F. Harrison, Registrar

Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/20, 1922, to 5/24, 1922, that I last saw h[illegible] alive on 5/24, 1922, and that death occurred, on the date stated above, at 4:10 p.m.

The CAUSE OF DEATH* was as follows:

Ophthalmia Neonatorum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chorea

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical methods

(Signed) [illegible], M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crisfield Md DATE OF BURIAL May 26 1922

20 UNDERTAKER William Cook ADDRESS 502 E Nath

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

25 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64615

CERTIFICATE OF DEATH.

D 64615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 16 WARD)

2-FULL NAME William Rupp

(a) RESIDENCE. NO. 1104 Appleton St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 19 - 1905

7 AGE Years 16 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. U. Tel. Co.

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER George H. Rupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Geo H Rupp nearest relative

15 MAY 25 1922 19 Robert P. Harrison, Registrar

Burial Permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23 - 1922, to May 24 1922, that I last saw h[illegible] alive on May 24 - 1922, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto City -

Did an operation precede death? Yes Date of May 23-1922

Was there an autopsy? Yes

What test confirmed diagnosis? Path exam of tissue

(Signed) Warfield M. Firor, M. D.

5/25 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — DATE OF BURIAL: May 27, 1922

20 UNDERTAKER: Wm Cook, 5076 E. North ave. ADDRESS

MAKE STRONG BLACK MARKS in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64616 57 D 64616

REGISTERED NO.

D 64616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Ashburton St. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Howard Forsyth

(a) RESIDENCE NO. 1727 Ashburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 0 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances M. Forsyth

6 DATE OF BIRTH (month, day, and year) May 6 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert Forsyth

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant mrs. Forsyth
(Address)

15 May 25, 19 22 Robert P. Harrison, Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922, to May 23rd, 1922, that I last saw him alive on May 22, 1922, and that death occurred, on the date stated above, at 12.40 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion & Lungs
about 9 hours
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 2 5 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Usual.

(Signed) G. Lehoh Ewalt M. D.

5/24, 19 22 (Address) 905 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 5/26 19 22

20 UNDERTAKER J. Fred McCully ADDRESS 1306 E. Fort

Spec.—5-19-13—M. & T.—500 Bks.

Antonina Simon

D 64617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64617

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 Radnor ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Simon

(Residence in Baltimore: No. 511 Radnor ave Jovan'i St.: 33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1835 (Year)

7-AGE, 87 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Simon

(Address) 511 Radnor ave

15- Robert P. Harrison, 191.....

25 1922 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1922, to May 23 1922, that I saw h[illegible] alive on May 22 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) S. W. Bishop M. D.

May 24, 1922 (Address) 520 E. Thirden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 3 mos. 22 ds. In the State 30 yrs. mos. ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, May 26, 1922

20-UNDERTAKER John McTeby

ADDRESS 1803 Bank St

CAUSE OF DEATH is important. See instructions on back of certificate 5 2 22

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64618

CERTIFICATE OF DEATH.

113 D 64618

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE. (No. 14 Hazel Court ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Walter Sobolewski

(Residence in Baltimore: No. 14 Hazel Court St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 7, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John F. Sobolewski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Alex. Merek

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Sobolewski

(Address) 14 Hazel St.

15- Robert P. Harrison,

Filed ....., 191.....

Registrar.

Burial Permit Clerk.

25 1922

CAUSE OF DEATH. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24th, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 15 1922, to May 24th 1922, that I saw h[illegible] alive on May 23rd 1922, and that death occurred, on the date stated above, at 10:40 m.

The CAUSE OF DEATH* was as follows:

Decubitus & Gastro Enteritis

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) D. Hartzenstein M. D.

May 24th, 1922 (Address) 1320 Johns

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, May 26, 1922

20-UNDERTAKER Wm. Fairgrounds ADDRESS 618 Carlton

Spec.—1-10-21—M&T—1500 Bks.

Price. 1012 Madison Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64619

CERTIFICATE OF DEATH.

44 D 64619

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Eutaw Place, 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Williamina Folckemer

(a) RESIDENCE NO. 1912 Eutaw Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	62	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Companion

(b) General nature of Industry, business, or establishment in which employed (or employer) 986

(c) Name of employer

9 BIRTHPLACE (city or town) Shrewsbury (State or country) Pa.

PARENTS

10 NAME OF FATHER Henry Folckemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Agnes Grahm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Clara Folckemer
(Address) Shrewsbury Pa.

15 Filed Feb. 19, 1922 R. P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 8th, 1922 to May 25, 1922

that I last saw her alive on May 25, 1922

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

of not less than 4 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia gradually increased (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? None needed

(Signed) Eleanor C. Price M. D.

May 25 1922 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shrewsbury Pa — DATE OF BURIAL May 25 1922

20 UNDERTAKER Wm Cook — ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64620 D 64620

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Emersonian Apts. 13 WARD)

2-FULL NAME Augusta Schwartz

(a) RESIDENCE NO. Emersonian Apts ST., Eutaw Place

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Schwartz

6 DATE OF BIRTH (month, day, and year) Dec. 21, 18 41

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	80	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hoffheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. S. Greif

(Address) Emersonian Apts.

15 MAY 25 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25/ 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21 1922 to May 25 1922

that I last saw h alive on May 25 1922

and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis; arteriosclerosis

(duration) yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) secondary anemia

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual physical exam and blood examination

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 10 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn New York

DATE OF BURIAL 5/26 1922

20 UNDERTAKER David Sonneborn

ADDRESS 1820 Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64621

CERTIFICATE OF DEATH.

K 179

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2 Anthony Ave ST., Ridgelong WARD)

2-FULL NAME Robert A. Jenkins

(a) RESIDENCE NO. Newland Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jenkins

6 DATE OF BIRTH (month, day, and year) March 25th 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) General Contracting

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Co. (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Jenkins

11 BIRTHPLACE OF FATHER (city or town) Richmond Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant J. C. Jenkins (Address) Newland Va.

15 MAY 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to May 25, 1922, that I last saw h[illegible] alive on May 25, 1922, and that death occurred, on the date stated above, at 3:50 p. m.

The CAUSE OF DEATH* was as follows: over

Uremia and Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis. Enlarged Prostate

Tumor. (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Exam.

(Signed) Wm Cappage, M. D.

May 26 1922 (Address) 2303 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem. Richmond Co. Virginia	May 28 1922

20 UNDERTAKER	ADDRESS
Fred Lockhart Sons	Fulkerson Bros.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis

Broncho pneumonia

Nonmalignant tumor

Spec.—6-9-19—H. P. Co.—1000 Bks.

64622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113D 64622
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 343 S. Calhoun ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Raymond A Gill

(a) RESIDENCE. No. 343 S Calhoun ST., 19 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ~~May 26 1922~~ Oct 3 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles E. Gill

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs. Dorothy Gill
(Address) 343 S. Calhoun

15 Filed MAY 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 26 May 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to May 26, 1922, that I last saw h[illegible] alive on May 24, 1922, and that death occurred, on the date stated above, at 6¾ a. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions at birth (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Stool, blood & history of convulsions

(Signed) J. McPhillips, M. D.

, 19 (Address) 2300 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	5-27 1922
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Hollins sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 64623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 D 64623

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital (or near) St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren Powell

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	S

6-DATE OF BIRTH, Not known, 1 (Month) (Day) (Year)

7-AGE. About 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Ont

9-BIRTHPLACE. (State or Country). Not known

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Lily Orr

(Address) 1639 N. Broadway

15- MAY 26 1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry; thereon and from the evidence obtained by said Inquest, autopsy or inquiry; and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of abdomen

Homicidal

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Coroner.

May 23, 1922 (Address) 1639 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	May 26, 1922
20-UNDERTAKER	ADDRESS
E. J. Fanning & Son	1738 E. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64624

CERTIFICATE OF DEATH.

24-01 OB 64624

1-PLACE OF DEATH Hebrew aged Home for Infirm REGISTERED NO.

CITY OF BALTIMORE: (No. 2102 E Baltd St. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Jacks

(a) RESIDENCE NO. 2102 E Balt St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If ooo-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1826

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1739 E Balt st

15 Filed MAY 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25. 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1921 to May 24 1922, that I last saw h-r alive on May 24 1922, and that death occurred, on the date stated above, at 11-0 m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stewart Hirshberg M. D.

19 (Address) 1592 W Lomb St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Shom DATE OF BURIAL 5/26 1922

20 UNDERTAKER Jack Lewis ADDRESS 1739 E Balt st

mation should be carefully supplied. Information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64625

D 64625

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Orphan & Home for Incurables

CITY OF BALTIMORE: (No.) 2102 E Baltimore ST. 14 WARD)

2-FULL NAME Minnie Winternitz

(a) RESIDENCE NO. 2021 Madison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Baltimore St

15 Filed MAY 26 1922, 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1920, to May 4 1922, that I last saw h alive on May 4 1922 and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

ch. interstitial nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Solomon Strauss M. D.

, 19 (Address) 1392 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem DATE OF BURIAL 5/26 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

mation should be carefully sought for, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64626

REGISTERED NO. 44 D 64626

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3121 - Calvert St (St.) 12 (Ward)

2-FULL NAME. Joseph Blake (Sr.)

(a) RESIDENCE. No. same St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Allnutt

6 DATE OF BIRTH (month, day, and year): 3/21/1841

7 AGE: Years 81 Months 2 Days 2 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Joseph Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Christina Grosscurtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Joseph Blake (Sr.) Blake Co

15 Filed MAY 26 1922 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/23/1922

17 I HEREBY CERTIFY, That I attended deceased from 5/1/1921 to 5/23/1922

that I last saw him alive on 5/23/1922

and that death occurred, on the date stated above, at 8.55 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile debility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Stanley Grossman

19 (Address) 3900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery, May 26, 1922

DATE OF BURIAL

20 UNDERTAKER: Henry W. Mears & Son, 805 N. Calvert

ADDRESS

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Thos. Moore

D 64627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64627

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Hse~~ Mercy Hospital ST. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2-FULL NAME Thos. Moore

(Residence in Baltimore: No. 426 N. Patterson Park Ave abt 35 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Commission Dry
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Merchant

9-BIRTHPLACE. (State or Country), N. York

PARENTS.

10-NAME OF FATHER, Thos Moore

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Mc Cormack

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ad Moore

(Address) 426 Pat Pk.

15-

FILED MAY 26 1922 Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24th A.M. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Arteri Sclerosis
Abt 5 yrs. (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Quadri
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Daly M. D.
(Coroner.)

May 25, 1922. (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetary

DATE OF BURIAL, May 26 1922

20-UNDERTAKER J Ulrich

ADDRESS 2008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each answer is important. See instructions on back of certificate.

D 64628

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64628

CERTIFICATE OF DEATH.

2459-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 E. Barney St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Earl W. Herbert.

(Residence in Baltimore: No. 109 E. Barney St. St.; yrs. ---- mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. April 30th. 1922. (Month) (Day) (Year)

7-AGE. ---- yrs. 24 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George Herbert.

11-BIRTHPLACE OF FATHER. (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Virginia Wisner.

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Herbert. (mother)

(Address) 109 E. Barney St.

15- MAY 26 1922 Filed ..... 192 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 24th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency. congenital.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Otto W. Reinhardt M. D. (Coroner.)

May 25th 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. May 26 1922

20-UNDERTAKER. Elmer W. Conkle ADDRESS 924 E. Eager St.

state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64629

CERTIFICATE OF DEATH.

51 D 64629

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 407 Mc Culloh ST.: (or) WARD) 14

2-FULL NAME Helen Wiggins

(a) RESIDENCE. No. 1407 Mc Culloh ST., 14 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence Wiggins

6 DATE OF BIRTH (month, day, and year): Dec. 26-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Whaley Va

PARENTS

10 NAME OF FATHER: Wm L Drake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ella Langston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Clarence Wiggins 1407 Mc Culloh Ave.

15 Filed MAY 26 1922 ROBERT R. KRAUTER, City Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922 to May 25, 1922

that I last saw her alive on May 25, 1922

and that death occurred, on the date stated above, at 7:35 A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Articular Rheumatism

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. B. Hughes, M. D.

May 26, 1922 (Address) 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Whaley Va | DATE OF BURIAL: May 26 1922

20 UNDERTAKER: Clarence Wiggins | ADDRESS: 1407 Mc Culloh

1—CAUSE OF DEATH in plain terms, so that it may be properly classified. 2—OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Full. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64630

CERTIFICATE OF DEATH.

1922 D 64630

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Carroll Ave St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME - Sallie A Full

(a) RESIDENCE. NO. 712 Carroll Ave St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo A. Full

6 DATE OF BIRTH (month, day, and year) May 29-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md - Worcester Co

PARENTS

10 NAME OF FATHER Ambrose Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sallie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo A Full (Address) 712 Carrollton

15 FILED MAY 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/4, 1922, to 5/25, 1922, that I last saw h[er] alive on 5/24, 1922, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Melville M. D.

May 27, 1922 (Address) 1271 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pocomoke City Md — DATE OF BURIAL: May 27 1922

20 UNDERTAKER: Geo M. Fisher & Son — ADDRESS: 811 N Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64631

CERTIFICATE OF DEATH.

D 64631

161

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE (No. ..... ST., 26 WARD)

2-FULL NAME Vincent Paul Stack

(a) RESIDENCE NO. Bayview Hospital ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 3 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
3 days.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) do.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Stack

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Bayview Hospital
(Address) Balto, Md.

15 Filed MAY 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922 to May 22, 1922.

that I last saw h[illegible] alive on May 22, 1922

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Fredsmith M. D.

May 24 1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL
Obstetrical Department

MAY 2 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64632

CERTIFICATE OF DEATH.

45

D 64632

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Matthews

(a) RESIDENCE NO. 156 W. Presstman St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58 ?	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co., (State or country) Maryland

PARENTS

10 NAME OF FATHER Edgar Matthews

11 BIRTHPLACE OF FATHER (city or town) Harford Co., (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Maryland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 MAY 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1922 to May 24, 1922, that I last saw him alive on May 24, 1922, and that death occurred, on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Metastasis to Liver

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

5/25/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 5/27/22 19

20 UNDERTAKER Sam. W. Chase-son

ADDRESS 1400 Mosher st

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64633

CERTIFICATE OF DEATH.

D 64633 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2325 Division St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Smith

(Residence in Baltimore: No. 2325 Division St., St.; 12 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): married

6-DATE OF BIRTH: about (Month) 1870 (Year) (Day)

7-AGE: about 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: home duties
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE, (State or Country): N. Carolina

PARENTS.

10-NAME OF FATHER: Crawford Boyd

11-BIRTHPLACE OF FATHER, (State or Country): N.C.

12-MAIDEN NAME OF MOTHER: Levi J. Boyd

13-BIRTHPLACE OF MOTHER, (State or Country): N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Maddix

(Address) 562 Baker St.

15- Filed MAY 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Jury (Inquest, Autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac. Def. of Heart 15 min

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

May 23 1922 (Address) 2102 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: High Point Station, N.C.

DATE OF BURIAL: May 26 1922

20-UNDERTAKER: Edward Ringgold

ADDRESS: 1463 Carey St

state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

D 64634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C 23170

City of BALTIMORE: (No. Franklin Street Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Viel

(Residence in Baltimore: No. 1434 S. Charles St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June (Month) 5 (Day) 1884 (Year)

7-AGE. 37 yrs. 4 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist 1021
(b) General nature of Industry, business, or establishment in which employed (or employer) Bro Shops

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Conrad Viel

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER Wilhelmena Hess

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Flora Viel

(Address) 109 N. Cary St.

15- Robert P. Harrison,

Filed ..... 192 ..... Burial Permit Issued ..... Registrar.

Y 2 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 25 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound in Brain
Self Inflicted Suicide

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Kemler M. D. (Coroner.)

May 25 1922 (Address) 700 E. Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)
At place of death ..... yrs ..... mos. 2 ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

109 N. Cary St

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	May 27th 1922
20-UNDERTAKER, C. W. Dill	ADDRESS 3109 Frederick Ave.

state CAUSE OF DEATH in plain terms, so that it may be understood. This is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 801 B 64635

118

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St Josephs Hospital ST.; 8 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Giovanni Bersotti

(Residence in Baltimore: No. 1917 N. Eden E Federal St.; 50 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec (Month) 15 (Day), 1853 (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Art Goods
(b) General nature of industry, business, or establishment in which employed (or employer) Plaster Paris Obj

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Giovanni Bersotti

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Dorothea Lenzi

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Manny Bersotti

(Address) 1917 E. Federal

15- Filed ....., 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk.

6 1922

CAUSE OF DEATH to be filled in plain terms. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 23 1922, to May 23 1922, that I saw h m alive on May 23 1922, and that death occurred, on the date stated above, at 8.25 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(Duration) yrs. mos. 2 hrs. ds.

CONTRIBUTORY (Secondary) Strangulated Hernia

(Duration) yrs. mos. 3 ds.

(Signed) Harold C. Gillsbury M. D.

5/23, 1922 (Address) 410 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cemetery Inc — DATE OF BURIAL, May 27, 1922

20-UNDERTAKER Pabst Johnson — ADDRESS 44 Druid

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64636

CERTIFICATE OF DEATH.

100 001 D 64636

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 E. Biddle ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Conway

(Residence in Baltimore: No. 400 E. Biddle St. 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Sept. (Month) 30 (Day), 1856 (Year)

7-AGE: 31 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Actor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Michael Conway

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary A. Morrissey

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Conway

(Address) 400 E. Biddle St.

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

1922 Burial Permit Clerk

CAUSE OF DEATH. Physician is required to report to the Health Department the Primary Cause which is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: May (Month) 24 (Day), 1922 (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 24 1922, to May 24 1922, that I saw h im alive on May 24 1922, and that death occurred, on the date stated above, at 8.50 m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)..... (Duration) yrs. mos. ds.

(Signed) Geo. M. Gill, M. D.

May 27, 1922 (Address) 7 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, May 27..., 1922

20-UNDERTAKER H. C. Windsfeld — ADDRESS 917 Fremont Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64637

CERTIFICATE OF DEATH.

47 D 64637

D 64637

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1016 N. Calvert ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie D. Holloway.

(a) RESIDENCE. NO. 1016 N. Calvert. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Charles T. Holloway

6 DATE OF BIRTH (month, day, and year) July 30th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Schelhases

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles T. Holloway

(Address) 1016 N. Calvert St.

15 Filed MAY 26 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to May 24, 1922

that I last saw h.. alive on May 24, 1922,

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with Metastasis

(duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Disease

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of Nov 2-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 27, 1922 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: May 27 1922

20 UNDERTAKER: Mrs. J. W. Tenfel & Son ADDRESS: 901 W. Fayette

CAUSE OF DEATH in plain terms, so that it can be understood by the public. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64638

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 D 64638

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 15 WARD)

2-FULL NAME Carrie Blanche

(a) RESIDENCE No. 728 Cumberland St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: John Blackiston

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Mary's Maryland

12 MAIDEN NAME OF MOTHER: Sarah Berry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co., Maryland

14 Informant (Address): Hospital Records, Municipal Hospital.

15 MAY 26 1922, 19 Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19 22, to May 25, 19 22, that I last saw h[illegible] alive on May 25, 19 22, and that death occurred, on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Mitchell M. D.

5/25/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: May 27 1922

20 UNDERTAKER: Mrs Hus John H. Teufel & Son — ADDRESS: 3d W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64639

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 64639

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 E. Hoffman Ave ST., 15 WARD)

2-FULL NAME Charlotte E. King

(a) RESIDENCE NO. 6 E. Hoffman Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 24-1897

7 AGE. Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER A. J. King

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Ada E. Reynolds

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant A. J. King
(Address) 6 E. Hoffman Ave

15 MAY 26 1922 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch 7. 1922 to May 25 1922.
that I last saw h[illegible] alive on May 25 1922, 19 ..., and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:
Organic Heart - Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Articular Rheumatism
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Colin Murray M. D.
May 26 1922 (Address) 1321 W. Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL May 27 1922

20 UNDERTAKER Horace H. Burgee — ADDRESS 3631 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64640

CERTIFICATE OF DEATH.

74 001

D 64640

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3980 Elm Ave ST., 13 WARD)

2-FULL NAME George T. Mixter

(a) RESIDENCE NO. 3980 Elm Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Mixter

6 DATE OF BIRTH (month, day, and year) July 29-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Columbus Mixter

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Harriett Lindmore

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant George T. Mixter Jr. (Address) 290 Bernard St.

15 [illegible] 28 1922 , 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1922, to May 24, 1922, that I last saw h alive on May 24, 19 , and that death occurred, on the date stated above, at 9 35 P, m.

The CAUSE OF DEATH* was as follows:

Hopelessly

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. B. Norment, M. D.

6-26 1924 (Address) 354 Cathedral Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL May 27 1922

20 UNDERTAKER Horace H. Burgie ADDRESS 365 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64641

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH Baltimore and Payson Sts.

CITY OF BALTIMORE: (No. German Aged Home St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albertine C. Zunker

(a) RESIDENCE. NO. 705 N Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residance in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman F. Zunker

6 DATE OF BIRTH (month, day, and year) Dec 23 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leonora Kiefley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant German Aged Home records (Address) Balto and Payson Sts.

15 Filed MAY 26 1922, 19

Robert P. Hart, M.D.
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from April, 1922, to May 25, 1922, that I last saw her alive on " 24, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of -

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Wolff M. D.

19 (Address) 1843 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 27 19 22

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64642

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 N. Calhoun ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Edwin Dobbs

(a) RESIDENCE. NO. 820 N. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Adeline Dobbs

6 DATE OF BIRTH (month, day, and year) May 6-1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Owned carpenter market

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Adolph Dobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Miss Schoolfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Mary Lysell (Address) 920 N. Calhoun St.

15 Filed MAY 26 1922, 19 Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25- 1922.

17

I HEREBY CERTIFY, That I attended deceased from May 13- 1922, to May 25- 1922, that I last saw him alive on May 25- 1922, and that death occurred, on the date stated above, at 11-00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gen. Urine etc.

(Signed) Chas. T. McCarthy, M. D.

, 19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	May 27 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64643

CERTIFICATE OF DEATH.

D 64643

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1449 Henry ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen A Smith

(a) RESIDENCE. No. 1449 Henry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 4 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo F Smith

11 BIRTHPLACE OF FATHER (city or town) Annapolis Md.
(State or country)

12 MAIDEN NAME OF MOTHER Marie Struttman

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Geo F Smith
(Address) 1449 Henry St.

15 Filed , 19 Registrar

27 1922

Robert E. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to May 26, 1922, that I last saw him alive on May 26, 1922, and that death occurred, on the date stated above, at 7-20 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signed L E L Campbell M. D.

May 26, 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Co	5/27 1922
20 UNDERTAKER	ADDRESS
William Cook	501 E Nor

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

(William H. Palmer)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64644 D 64644

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C 590

CITY OF BALTIMORE: (No. 1362 Woodyear ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. H. Palmer.

(Residence in Baltimore: No. 1362 Woodyear St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, (Month) (Day) (Year): 1877

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watch Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 039

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Calvin H. Palmer

(Address) 548 W. Lafayette ave

15- Robert P. Harrison,

Filed ....., 191.....

MAY 27 1922 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) May (Day) 25, (Year) 1922

17- I HEREBY CERTIFY, That I attended deceased from May 7 1922, to May 25 1922, that I saw h[illegible] alive on May 22 1922, and that death occurred, on the date stated above, at 11.00 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. ds.

(Signed) W. J. Carr, M. D.

May 26, 1922 (Address) 515 Fawcett St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, mt auburn — DATE OF BURIAL, May 28, 1922.

20-UNDERTAKER Joseph A Farrell — ADDRESS 2319 Division St

Check for accuracy before signing. See instructions on back of certificate. important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64645

100-001

100-D 64645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 761 W Mulberry ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Veronica Fulton

(a) RESIDENCE NO. 761 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 2-1921

7 AGE: Years — Months: 6 — Days — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (City or town): Ballard Dunn

(State or country): Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Louisa Fulton

13 BIRTHPLACE OF MOTHER (City or town)

(State or country): Va

14 Informant: Louise Fulton

(Address): 761 W Mulberry

15 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to May 26, 1922, that I last saw her alive on May 26, 1922, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) W B Thompson M. D.

5/26 1922 (Address) 609 10 Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT Auburn

DATE OF BURIAL: May 27 1922

20 UNDERTAKER: Daniel Easter

ADDRESS: 914 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Contagious diseases. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64646

CERTIFICATE OF DEATH.

162 D 64646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Chester ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Kreppel.

(a) RESIDENCE NO. 616 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced WIFE of (or) HUSBAND of

6 DATE OF BIRTH (month, day, and year): May 25 1922

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frederick Kreppel.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Barbara E. Zorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Frederick Kreppel. (Address) 616 N. Chester St.

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1922, to May 26, 19 .

that I last saw him alive on May 26, 1922,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Howard B. Litton M. D.

, 19 (Address) 315 Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: May 29 1922

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

27

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of twisted umbilical cord. Knotted

Spec.—1-10-21—M&T—1500 Bks.

D 64647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64647

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 Brunt ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Sullivan

(a) RESIDENCE No. 2230 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. / mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Daniel Sullivan

6 DATE OF BIRTH (month, day, and year) Aug 4 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md.

PARENTS

10 NAME OF FATHER Robert Guby

11 BIRTHPLACE OF FATHER (city or town) Talbot Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Betty Guby

13 BIRTHPLACE OF MOTHER (city or town) Talbot (State or country) Md

14 Informant Mary Williams (Address) 1310 Penna Ave

15 Filed ... 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to May 25, 1922, that I last saw h.~~e~~ alive on May 24, 1922, and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

5/25, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dixfield, Maryland	May 28, 22
20 UNDERTAKER	ADDRESS 1302
Samuel H. Adams & Co	Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] TION is very important. See instructions on back of certificates.

Y 27 1922

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64648

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Scott

(a) RESIDENCE. No. 753 W. Saratoga st. St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Daniel Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M. T. H.

15 Date 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1922, to May 24, 1922, that I last saw him alive on May 24, 1922, and that death occurred, on the date stated above, at 8.40 p. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Lung abscess and gangrene

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Francis L. Dalaglacer M. D.

5-25- 19 22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn

DATE OF BURIAL: May 27 1922

20 UNDERTAKER: John H Owens

ADDRESS: 873 W Dodd St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64649

CERTIFICATE OF DEATH.

96 D 64649

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvin Singleton

(a) RESIDENCE. NO. 406 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2nd 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ppp

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Singleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Jenkins.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs Florence Singleton
(Address) 406 E Biddle st

15 Filed 5-26-1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1922, to May 26, 1922, that I last saw him alive on May 25, 1922, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis
Mitral Stenosis and Insufficiency

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) adhesive pericarditis

(duration) unknown ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gordon L. Seagrave M. D.

5-26 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 29th 1922
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1116 E Monument

Spec.—1-10-21—M&T—1500 Bks.

D 64650 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D 64650

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 442 E. North Ave.

REGISTERED NO.

CITY OF BALTIMORE: (No. 442 E. North Ave. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McConnell

(a) RESIDENCE NO. 442 E. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 Years Mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The late Mary McConnell

6 DATE OF BIRTH (month, day, and year) April-15-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Quarryman

(b) General nature of industry, business, or establishment in which employed (or employer) 686

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER John. McConnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rebecca McCreary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Miss. Rena. H. McConnel [illegible] Ave.

MAY 27 1922 Robert P. Harrison 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-26-1922

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 26, 1922,

that I last saw him alive on May 25, 1922,

and that death occurred, on the date stated above, at 12:40 A. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia & Bacteria & Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin Paralysis

(Signed) C. O. Carman, M. D.

5-26, 1922 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosehill Cemetery Calvert Cecil Co. Maryland

DATE OF BURIAL May-29-19[illegible]

20 UNDERTAKER Henry Hoeck Son

ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF DISEASE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64651

129 D 64651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 N. Durham St. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Reinfelder

(a) RESIDENCE NO. 1638 N. Durham St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 35 yrs. 6 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Reinfeldner

6 DATE OF BIRTH (month, day, and year) May-10-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	--	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Fleischerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant (Address) Mr. Bernard Reinfelder 1638 N. Durham St.

15 Filed 19 Robert P. Harrison, Registrar

27 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-27-1922

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1922, to May 27, 1922, that I last saw h W alive on May 26, 1922, and that death occurred, on the date stated above, at 5:20 A.M m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jacob Frisch, M. D.

5/27/1922 (Address) 1823 N. Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May. 30 1922

20 UNDERTAKER: Henry Stosch Son — ADDRESS: 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF DISEASE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64652

CERTIFICATE OF DEATH

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 N. Washington St., WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Rieffe

(a) RESIDENCE NO. 1320 N. Washington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dont know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House man

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Paris France

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Paris France

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Paris France

14 Informant: Mrs Vosen (Address) 1320 N Washington St

15 Filed MAY 27 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1922, to May 24, 19 22, that I last saw h[illegible] alive on May 24, 19 22, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank J. Ayd, M. D.

May 26, 1922 (Address) 2006 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney

DATE OF BURIAL: May 27 19 22

20 UNDERTAKER: Robt J. Turner Inc

ADDRESS: 1 W. Mt. Royal

INFORMATION should be carefully supplied. Exact statement of occupation, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64653

HEALTH DEPARTMENT—CITY OF BALTIMORE

1629 64653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 (Street) Druid Hill Ave (Ward) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Citro

(a) RESIDENCE NO. 704 (Street) Druid Hill Ave (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 14 22

7 AGE — Years: — Months: — Days: 1½ — If LESS than 1 day 36 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Eugene Citro

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rose Alafonto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Eugene Citro

(Address) 704 Druid Hill Ave

15 Filed MAY 27 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/26/1922

17 I HEREBY CERTIFY, That I attended deceased from 5/25/, 1922, to 5/26/, 1922 that I last saw h[illegible] alive on 5/26/, 1922 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank E Mahrer, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL: May 27 1922

20 UNDERTAKER: Wendel Dippel & Son — ADDRESS: 372 S. Conn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64654

CERTIFICATE OF DEATH.

179 D 64654

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 Watson St ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Moore

(Residence in Baltimore: No. 1138 Watson st St.: 7 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	colored	married

6-DATE OF BIRTH, Sept 13, 1855
(Month) (Day) (Year)

7-AGE, 66 yrs. 8 mos. ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grain Trimmer
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER, John Moore

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER Alice Moore

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Moore

(Address) 1138 Watson X

15-

Filed MAY 27 1922 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 31 1922, to May 26 1922, that I saw h alive on May 25 1922, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) .....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(Duration) .....yrs. 3 mos.....ds.

(Signed) Holman [illegible] M. D.

May 26, 1922 (Address) 1217 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury | DATE OF BURIAL, May 27, 1922

20-UNDERTAKER John W Henderson | ADDRESS 1502 E monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64655

CERTIFICATE OF DEATH.

L 170 D 64655

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1730 Ellamont St., ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd D. Addison

(Residence in Baltimore: No. 1730 Ellamont St., St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 21, (Month) (Day), 1869 (Year)

7-AGE, 53 yrs. 1 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... U. S. Govt.

9-BIRTHPLACE, (State or Country), Va,

PARENTS.

10-NAME OF FATHER, Augustus E. Addison

11-BIRTHPLACE OF FATHER (State or Country), Md,

12-MAIDEN NAME OF MOTHER Mary E. Girard

13-BIRTHPLACE OF MOTHER (State or Country), Miss.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank G. Addison

(Address) Mitchellville, Md.

15- Robert P. Harrison,

Filed....., 191.....

MAY 27 1922 Burial Permit Clerk. Registrar.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the date stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gun shot wound in head. (Instantaneous death)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 26 1922 (Address) 2702 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington D. C.

19-PLACE OF BURIAL OR REMOVAL, Lorraine Park Cemetery — DATE OF BURIAL, May 27, 1922

20-UNDERTAKER Chas. G. Black — ADDRESS 7424 North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64656

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 766 Sarah Ann ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Talbott

(a) RESIDENCE. No. 766 Sarah Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co. Md

PARENTS

10 NAME OF FATHER Richard Carroll

11 BIRTHPLACE OF FATHER (city or town) St Marys (State or country) Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Lawrence

13 BIRTHPLACE OF MOTHER (city or town) St Marys (State or country) Co Md

14 Informant Elizabeth Carroll.
(Address) 232 Bore Alley

15 [illegible] 19 Robert P. Harrison Registrar

27 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9— 1922 to May 25 1922

that I last saw her alive on May 24th 1922

and that death occurred, on the date stated above, at 12 — m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Dont Know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bright Disease

Dont Know (duration) yrs. mos. ds.

18 Where was disease contracted. If not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? — What test confirmed diagnosis? Examination

(Signed) Samuel A Bain, M. D.

19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn	May 28 19 22

20 UNDERTAKER ADDRESS

P B Gross 1405 W Mt [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64657

D 64657

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. St. Agnes Hospital St., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Lavinia Goddard

(a) RESIDENCE No. 1428 John St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 76 yrs Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs. Naomi Kidd (Address) 1428 John St.

15 Filed MAY 27 1922, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-11, 1921, to 5-25, 1922, that I last saw h[illegible] alive on 5-25, 1922 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Not known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical—History

(Signed) C. C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 5-29-1922

20 UNDERTAKER H. C. Bowman & Son

ADDRESS 517 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64658

CERTIFICATE OF DEATH.

4 K 23

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julianna T. Gratzky.

(a) RESIDENCE. NO. Forrna Park, Md. ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Edward Gratzky.

6 DATE OF BIRTH (month, day, and year): 1887.

7 AGE: Years: 33 yrs. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Muhlehan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Sanders.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Geo. Gratzky (Address) 1000 E. Fayette St.

15 Filed 19 Robert P. Harrison, Registrar

27 1922

Burial Permit Mailed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/25 1922.

17

I HEREBY CERTIFY, That I attended deceased from 5/17/22, 1922, to 5/25, 1922, that I last saw h[illegible] alive on 5/25, 1922 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis Lethargic type

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes.

(Signed) Thos Sheldon M.D. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: May 27 1922

20 UNDERTAKER: Geo J Smith

ADDRESS 1000 E. Fayette St

CAUSE OF DEATH in plain terms. Secondary or contributory cause should be stated. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15-6097 D 64659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002 D 64659

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Atkinson

(a) RESIDENCE. No. 1370 Stockton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Mary Atkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Robert P. Harrison, Jr.

15 Filed ....., 19.... Registrar

5/27 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23rd, 1922, to May 23rd, 1922, that I last saw h[illegible] alive on May 23rd, 1922, and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Birth Injury - Brain hemorrhage -

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes —

What test confirmed diagnosis? None.

(Signed) Horace G. Stewart, M. D.

5/26, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS

MAY 23 1922

Commissioner Health.

CAUSE OF DEATH to be given in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

(Dee Roberson)

D 64660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64660

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH U.S.V.HOSP.#56, Ft.McHenry, Md.

CITY OF BALTIMORE: (No. Mc Henry, Md. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ROBERSON, Dee

(a) RESIDENCE No. U.S.V.Hosp.#56, Balto.Md. ST., 606 Redwood St. Balto. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker's Hlpr.

(b) General nature of industry, business, or establishment in which employed (or employer) -- 086

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant HOSPITAL RECORDS, (Address) Ft.McHenry, Md.

15 Filed MAY 27 1922, 19 Registrar Robert P. Harrison, Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan.12, 1922 to May 24, 1922 that I last saw him alive on May 24, 1922, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Chr.Pulmonary Tuberculosis, far adv. and active.

(duration) - yrs. - mos - ds.

CONTRIBUTORY (Secondary) Pneumo Throx

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Laboratory report

(Signed) M. A. Foster Otw, M. D.

5/24 1922 (Address) SURGEON U.S.P.H.S. U.S.V.Hosp.#56, Ft.McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery.

DATE OF BURIAL May 27 1922

20 UNDERTAKER L. Funeral Director

ADDRESS 1127 E. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64661

38

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 ST.: 9 WARD)

2-FULL NAME Elizabeth Diskey

(a) RESIDENCE. NO. St. Elizabeth's Home Chestnut Hill Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: negro

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: — Months: 6 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Sarah E. Diskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address):

15 Filed ..... 19 ..... Registrar (Robert P. Harrison)

MAY 27 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from January, 1922, to May 25, 1922, that I last saw h[illegible] alive on May 25, 1922, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Marasmus

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

May 26, 1922 (Address) 2006 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER — ADDRESS

MAY 27 1922

Commissioner of Health,

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. THIS is very important.

D 64662 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64662

1-PLACE OF DEATH

Registered No. C 177

City of BALTIMORE: (No. 1044 Gaudy St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph Blume

(Residence in Baltimore: No. 1044 Gaudy St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX M

4-COLOR OR RACE W.

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~. (Write the word.) Single

6-DATE OF BIRTH Feb 5 1865
(Month) (Day) (Year)

7-AGE 57 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country) Germany

PARENTS.

10-NAME OF FATHER. —

11-BIRTHPLACE OF FATHER. (State or Country). —

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER. (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Niece

(Address)

15- May 27 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26 1922
(Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, an (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Ac Bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senat Alcohol

(Duration) yrs. mos. ds.

(Signed) C. E. Hodes M. D.
(Coroner)

May 26 1927 (Address) 1122 E. Biddle

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

MAY 27 1922

UNIVERSITY OF MARYLAND
LIBRARY
Commissioner Health.

MAY 27 1922

State CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64663

CERTIFICATE OF DEATH.

1001 74 D 64663

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1504 Caradis Court ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simms Coates

(Residence in Baltimore: No. 1504 Caradis Court St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, about ..... (Month) ..... (Day) 1877 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer). (Removal)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Northwestern Police Dept.

(Address) Penna. Ave.

15-

[illegible] 19.. [illegible] Registrar.

MAY 27 1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

May 26 1922 (Address) 2302 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, ..., 19....

20-UNDERTAKER Robert P. Harrison

ADDRESS MAY 27 1922

UNIVERSITY OF MARYLAND

THE HISTORICAL SOCIETY

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64664

CERTIFICATE OF DEATH.

179

D 64664

1-PLACE OF DEATH Municipal Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 16 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hussey

(a) RESIDENCE. No. Bay View ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Hussey

6 DATE OF BIRTH (month, day, and year) Feb 5 1852

7 AGE: Years 69 | Months 6 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hosp. Records

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MAY 27 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH STATEMENT OF PERSON. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from 10-10-1918, to 5-25, 1922 that I last saw him alive on 5-25, 1922 and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 yrs. — mos. — ds.

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

(Address) Municipal Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul Cemetery	May 27 1922
UNDERTAKER	ADDRESS
P B Huppert Funeral Co	2236 Eutaw Pl

Spec.--1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64665

X143 001

D 64665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin D. Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lenora Strong

(a) RESIDENCE NO. Bengies, Md ST., WARD Bengies Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) m

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of George W. Strong

6 DATE OF BIRTH (month, day, and year) Dec 19 1876

7 AGE Years 45 Months 5 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Uriah L P. Fosler

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary Powers

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Mary T. Strier (Address) 1028 N Luzerne ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 19 22

17 I HEREBY CERTIFY, That I attended deceased from 5/24 , 19 22 , to 5/25 , 19 22 ,

that I last saw h[illegible] alive on 5/[illegible] , 19 22

and that death occurred, on the date stated above, at 3.05 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Primary (Cause 3 mos. Primary)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Autop

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Path

(Signed) Newton J. Brown, M. D.

5/25, 19 22 (Address) Franklin D. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ebenezer Cemetery DATE OF BURIAL May 28 1922

20 UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

mation should be carefully supplied. Exact statement of DEATH in plain terms, so that it may be properly classified. CAUSE OF TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64666 D 64666

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4536 Harford Road ST., 3 WARD)

2-FULL NAME Hermina Bletzer

(a) RESIDENCE NO. 722 S. Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Bletzer

6 DATE OF BIRTH (month, day, and year) June 1, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Henry L. Brandes

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Meinert

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Henrietta Mugdan
(Address) 4536 Harford Road

15 Filed ..... 19 ..... Registrar
Robert P. Harrison,
Burial Permit Clerk.
27 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1922, to May 25, 1922, that I last saw h alive on May 25, 1922, and that death occurred, on the date stated above, at 9.53 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis Frank, M. D.

5/26, 19 22 (Address) 4536 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL May 28 1922

20 UNDERTAKER H. Sanders & Sons ADDRESS 1710 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64667

CERTIFICATE OF DEATH.

D 64667

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1529 E. Fayette St. 5 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Johnson

(a) RESIDENCE. No. 1529 E. Fayette St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sophia Johnson

6 DATE OF BIRTH (month, day, and year) July, 29 year?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
approx	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Mrs Sophia Johnson (wife) 1529 E Fayette St

15 Filed MAY 28 1922, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to May 26, 1922,

that I last saw h. alive on May 25, 1922,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Parenchymatous Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab

(Signed) R. J. Yonkey, M. D.

, 19 (Address) 1529 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem, Baltimore

DATE OF BURIAL May 30 1922

20 UNDERTAKER Mrs J. G. Locke

ADDRESS 1902 Jefferson

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64668

CERTIFICATE OF DEATH.

32D 64668

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 716 Ajax Al ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Harris

(a) RESIDENCE. NO. 716 Ajax Al. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none opt

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Morris Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) City.

12 MAIDEN NAME OF MOTHER Jessie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Jessie Harris
(Address) 716 Ajax St.

15 Filed MAY 28 1922, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1922, to May 24, 1922, that I last saw him alive on May 24, 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis Tuberculous

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Measles which ended
(duration) 1 mo ago yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Lindsay, M. D.

, 19 (Address) 14 29 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion	May 28 19 22
20 UNDERTAKER	ADDRESS
Mrs J. G Locks	1362 Jefferson St.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

64669 64669

HEALTH DEPARTMENT—CITY OF BALTIMORE

0164669

161-00 D 64669

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 70 E Carrollton Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen B. O'Brien

(Residence in Baltimore: No. 70 E. Carrollton Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 27 (Day), 1933 (Year)

7-AGE, ...yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

9-BIRTHPLACE, (State or Country), 70 E. Carrollton Ave Balto City

PARENTS.

10-NAME OF FATHER, John Paul O'Brien

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Mary Wade

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Paul O'Brien

(Address) 70 E Carrollton Ave

15-

Filed MAY 28 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27 1922, to May 27 1922, that I saw h[illegible] alive on May 27 1922, and that death occurred, on the date stated above, at 9 35 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Leonard O'Brien M. D.

May 27, 1922 (Address) 2[illegible] E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Pt Pleasant	May 29 1922
20-UNDERTAKER	ADDRESS
John L Fiddes 1205 N	Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question important. See instructions on back of certificate.

Simson

Srec.—6-9-19—H. P. Co.—1000 Bks.

D 64670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 64670

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Reservoir ST. 13 WARD)

2-FULL NAME Mina Moses Simson

(a) RESIDENCE. No. 808 Reservoir ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Simson

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 83 yrs; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bonn Germany

PARENTS

10 NAME OF FATHER: Moses Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bonn Germany

12 MAIDEN NAME OF MOTHER: Veit Hurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bonn Germany

14 Informant (Address): Julia Simson 808 Reservoir St

15 Filed MAY 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to May 25, 1922, that I last saw h[illegible] alive on May 25, 1922, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion & Influenza (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 808 Reservoir

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual tests + Examination

(Signed) Thos L Isabell M. D.

May 27, 1922 (Address) Marlboro Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: May 28 1922

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Mad ave

CAUSE OF DEATH to be plainly written, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105603 D 64671

K 107 003 D 64671

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.:) 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Stern. Atlantic City

(a) RESIDENCE. No. 412 Woodlyn Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mrs Anna Stern. wife

6 DATE OF BIRTH (month, day, and year) May 19 1877.

7 AGE: Years 45 Months — Days 8 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer. 34

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Moses Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 MAY 28 1922 ROBERT R. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 27, 1922, that I last saw h.. alive on May 27, 1922, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Lung abscess (non tuberculous)

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Philadelphia

Did an operation precede death? Yes Date of May 16, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P B MacCready, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: At Lantic City N.J.

DATE OF BURIAL: May 27 1922

20 UNDERTAKER: H. Lennon & Bro

ADDRESS 1127 E Balto St

CAUSE OF DEATH must be given in plain terms. DESCRIPTIVE TERMS OR ABBREVIATIONS ARE NOT SUFFICIENT. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 64672

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. monument ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Miriam Mofsowitz

(a) RESIDENCE. No. 3240 Frederick Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Abraham Mofsowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ann Mofsowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abraham Mofsowitz
(Address) 3240 Frederick Ave

15 Filed MAY 28 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2d, 1922, to May 27, 1922, that I last saw her alive on May 26 1922, and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acquired Hemolytic Jaundice

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 10, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

5/27, 1922 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Blvd

DATE OF BURIAL May 28 1922

20 UNDERTAKER Max Lerman

ADDRESS 1127 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for removal of spleen

Spec.—6-9-19—H. P. Co.—1000 Bks.

Garfinkel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64673 | 5 D 64673

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 W. Hill St.; 27 Ward)

2-FULL NAME Rosie Garfinkel

(a) RESIDENCE. No. 19 W. Hill St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Garfinkel

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Balto St

15 Filed MAY 28 1922 19 ROBERT R. KRAUTER, Registrar

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan., 5, 1917, to May, 27, 1922, that I last saw her alive on May, 27, 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia, Chronic Interstitial Nephritis, Chronic Myocarditis, Diabetes Mellitus

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? What test confirmed diagnosis? Clinical Course & Symptoms

(Signed) David Frankau M. D.

5/27, 1922 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehren Hessing Lun	5/28 1922
20 UNDERTAKER Jack Lewis	ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1553 19 3674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3V D 64674

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Miles

(a) RESIDENCE. NO. 1933 Aiquith ST., WARD.
(Usual place of abode) wife
Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) July 1, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ddd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Leona Miles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed MAY 28 1922 ROBERT R. [illegible] Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 — 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 17th, 1922, to May 26th, 1922, that I last saw he alive on May 26th, 1922, and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis —

(duration) ....yrs. ....mos. 26 ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture —

(Signed) Horace G. Stewart, M. D.

5/26, 1922 (Address) Johns Hopkins Hospital —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 28 1922
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

155959.
D 64675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 64675

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. ____ ST.: JOHNS HOPKINS HOSPITAL. WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Palmer

(a) RESIDENCE. NO. 612 Rutland Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced (HUSBAND of) (or WIFE of): Maria Jackson (niece),

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: 56 Years ? Months ? Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook 971
(b) General nature of industry, business, or establishment in which employed (or employer): Cook
(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS
10 NAME OF FATHER: Bennett Filchett
11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia
12 MAIDEN NAME OF MOTHER: Maria Bibbins
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 MAY 28 1922 ROBERT R. CRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922 to May 26, 1922
that I last saw her alive on May 26, 1922
and that death occurred, on the date stated above, at 1.50 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma liver - probably secondary to carcinoma pancreas.

(duration) ____ yrs. 3-4 mos. ____ ds.

CONTRIBUTORY (Secondary) ____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of May 26 1922
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) C. Sidney Burwell M. D.
. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: May 29 1922

20 UNDERTAKER: Mrs R A Elliott — ADDRESS 1715 Ashland Av

CAUSE OF DEATH must be filled in. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1716 N. Appleton ST.: 15 WARD)

REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rodney N. Shelton

(Residence in Baltimore: No. 1716 N. Appleton St. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... about ....., 1836
(Month) (Day) (Year)

7-AGE, ... 86 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... retired 862
(b) General nature of industry, business, or establishment in which employed (or employer)..... watchman

9-BIRTHPLACE, (State or Country), Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER, Denis Kean

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Shelton

(Address) 1716 N. Appleton St

15- MAY 28 1922, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May ..... 26 ....., 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease
(valvular & myocardial degeneration)
..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) arterio sclerosis
..... (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) ..... T. Hennessy ..... M. D.
(Coroner.)

May 28, 1922 (Address) 2502 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, 5 29, 1922

20-UNDERTAKER W. J. Jackson & Son

ADDRESS North & Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64677

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2247 E Chase ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cudlin

(a) RESIDENCE. No. 2247 E Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Cudlin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 72 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 500

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Cudlin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Cusick

(Address) 2247 E Chase

15 Filed MAY 28 1922 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 27, 1922

that I last saw h[illegible] alive on May 27, 1922

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) William J. Gesell M. D.

By [illegible] 19 (Address) 801 E Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: May 30 1922

20 UNDERTAKER: Frank Courtney

ADDRESS: 1906 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64678 D 64678

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Byrd St. ST., 24 WARD)

2-FULL NAME Mary A. Dehn

(a) RESIDENCE NO. 1728 Byrd St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT WORDING IS very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ira E. Dehn

6 DATE OF BIRTH (month, day, and year) Feb. 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 807

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Minister

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Ira E. Dehn
(Address) 1728 Byrd St.

15 MAY 28 1922 ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to May 26, 1921, that I last saw h. alive on May 26, 1921, and that death occurred, on the date stated above, at 12 45 am.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Ephanchias (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. K. Campbell M. D.

May 27, 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	May 30 1922
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E. Ford.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64679

CERTIFICATE OF DEATH.

101-001 D 64679

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Callow Avenue ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Carroll Blondell

(a) RESIDENCE. NO. 2314 Callow Avenue ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian League

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hat Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John A. Blondell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Burk

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Lillian L. Blondell
(Address) 2314 Callow Avenue

15 MAY 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922, to May 25, 1922, that I last saw h[er] alive on May 25, 1922, and that death occurred, on the date stated above, at 2 - P. m.

The CAUSE OF DEATH* was as follows:

Toxemia & Myocardial Insufficiency

(duration) .... yrs. .... mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) .... yrs. .... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore A. Morrison, M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/28, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

CAUSE OF DEATH in plain terms. Abbreviations must not be used.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64680

CERTIFICATE OF DEATH.

#9 D 64680

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 University Parkway ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Schaur Brooks

(a) RESIDENCE. NO. 653 University Parkway ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J. Brooks

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Martin Schaur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mathilda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles J. Brooks Jr.

(Address) 653 University Parkway

15 MAY 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 22

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to May 26, 1922, that I last saw her alive on May 26, 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cardio respiratory Collapse

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Endothelioma 3rd Stage,

(duration) ....yrs. 4 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur L Tekampe M. D.

5/27, 1922 (Address) 806 Cameron Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/29, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH must be plainly written, and all questions answered. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64681

CERTIFICATE OF DEATH.

74-001 D 64681

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3031 W. North Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Roberta Cooper James

(a) RESIDENCE. NO. 3031 W. North Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public School Teacher (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Official

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas C. James

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Miss Margaret James (Sister)

(Address) 3031 W. North Ave

15 Filed MAY 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26th, 1922 to May 27th, 1922 that I last saw her alive on May 26th, 1922 and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy.

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Isaac C. Dickson, M. D.

, 19 (Address) 3033 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 29 19
20 UNDERTAKER	ADDRESS
Milton W. Jones	444 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64682 HEALTH DEPARTMENT—CITY OF BALTIMORE 160 D 64682

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 Bank ST., W WARD)

2-FULL NAME Catherine Cummings

(a) RESIDENCE NO. 1919 Bank ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Luther Cummings

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Kress

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Barbara Cummings
(Address) 1919 Bank St

15 Filed MAY 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1922, to May 27, 1922, that I last saw h er alive on May 27, 1922, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

Inanition

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Since birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thomas J. Simms, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL May 29 1922

20 UNDERTAKER Funkler & Pikler — ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64683

D 64683

CERTIFICATE OF DEATH.

179

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N Carey St ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Josephine Bosley

(Residence in Baltimore: No. 504 N. Carey St.; 5yr yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1849 (Year)

7-AGE, 73 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Invalid
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER Lonza D. Taylor

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Eliza Jane McClain

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Bowen

(Address) Mt Washington

15- Filed MAY 28 1922, 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12 1922, to May 26 1922, that I saw h-e alive on May 26 1922, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Interstitial

Nephritis (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) John A. Evans M. D.

May 27 191 2 (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Greenmount Cem DATE OF BURIAL, May 29, 1922

20-UNDERTAKER R S Marshall ADDRESS 3539 Fallsroad

CAUSES OF DEATH should be stated with great care. Every item is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64684

CERTIFICATE OF DEATH.

D 64684

REGISTERED No. C 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Mondawmin Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winfield Taylor Miller

(Residence in Baltimore: No. 3400 Mondawmin Ave. St.; 16 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. 18th (Month) (Day), 1847 (Year)

7-AGE, 74 yrs. 5 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work minister
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Frederick, Md.

PARENTS.

10-NAME OF FATHER, George Miller

11-BIRTHPLACE OF FATHER (State or Country), Fred Co. Md.

12-MAIDEN NAME OF MOTHER Mary Lerner.

13-BIRTHPLACE OF MOTHER (State or Country), Fred Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. T. Miller

(Address) 3400 Mondawmin Ave

15- MAY 28 1922 Filed MAY 28 1922 191 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22 1922, to May 27th 1922, that I saw him alive on May 27th 1922, and that death occurred, on the date stated above, at 7.45a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. mos. 5 ds.

(Signed) Isaac C. Dickson M. D.

May 27. 1922 (Address) 30 S.S.W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery Frederick Md

DATE OF BURIAL, May 29., 1922

20-UNDERTAKER Geo J. Smith

ADDRESS 1000 Fayette st

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64685

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 4126 Falls Road ST., 13 WARD)

2-FULL NAME James H. C. Groves

(a) RESIDENCE NO. 4126 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Virginia L. Groves

6 DATE OF BIRTH (month, day, and year) June 22-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Mason

(b) General nature of industry, business, or establishment in which employed (or employer) O.K.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles D. Groves

(Address) 4126 Falls Road

15 MAY 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to May 27, 1922,

that I last saw him alive on May 27, 1922,

and that death occurred, on the date stated above, at 1 40 A m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. Unknown mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. H. Machen M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	May 29 22
UNDERTAKER Horace F. Burgee	ADDRESS 360 Fallsway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64686 001 74 D 64686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor, St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Cadwalader,

(a) RESIDENCE. No. Preston & Valley Sts. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 25 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Unknown	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward Cadwalader.

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Louisa Mills,

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence, Sup'r. (Address) Preston & Valley.

15 MAY 28 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19..., that I last saw her alive on May 24, 1922, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

May 25, 1922 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 29 1922

20 UNDERTAKER: Wm. C. Miller — ADDRESS: 2334 Jefferson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Paporo. ✓

D 64687

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Annapolis Road West 1715 ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas J Paporo

(a) RESIDENCE NO. annapolis Road West Port ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 25 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	3	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Mt Vernon Md
(State or country)

PARENTS

10 NAME OF FATHER Dominick Paporo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Elizabeth Grist

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Elizabeth Grist
(Address) West Port

15 MAY 28 1922 ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1922, to May 26, 1922,

that I last saw h in alive on May 26, 1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Felonus

Playing about a motor cycle causing the same to fall on his leg.

Accidental death (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) infection from broken leg

(duration) yrs. mos. 7 ds.

18 Where was disease contracted, if not at place of death? Frequent runaway

Did an operation precede death? Date of

Was there an autopsy? no Coroner

What test confirmed diagnosis? -

(Signed) Thos B Hall, M. D.

, 19 (Address) Hallethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL 5/29 1922

20 UNDERTAKER Mr-Mrs A S Finch — ADDRESS 1737 N Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

64688 HEALTH DEPARTMENT—CITY OF BALTIMORE 64688

D 64688 CERTIFICATE OF DEATH. X118 D 64688

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Barrett

(a) RESIDENCE NO. Smyrna Del ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gilbert Barrett.

6 DATE OF BIRTH (month, day, and year) Oct. 28 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	6	29	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER John Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Gilbert Barrett (Address) Smyrna Del

15 Filed MAY 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to May 27, 1922

that I last saw h[illegible] alive on May 27, 1922

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency,

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 10-27.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman J. Dorf, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odd Dal. Wetmiller, Smyrna DATE OF BURIAL 5/29/22 19

20 UNDERTAKER George J. Ruth ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64689

CERTIFICATE OF DEATH.

K 90

1-PLACE OF DEATH Hospital for the Women of Maryland REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Low Rowe

(a) RESIDENCE NO. Lansdowne, Maryland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of James C. Rowe

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
78				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER — Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Unknown

12 MAIDEN NAME OF MOTHER — Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address) Jas. C Rowe Jr. Lansdowne Md

15 Filed MAY 29 1922 ROBERT R. KNAUER, Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to May 27, 1922, that I last saw her alive on May 27, 1922, and that death occurred, on the date stated above, at 4:25 P. m.

The CAUSE OF DEATH* was as follows:

The patient had a myocardial insufficiency of marked degree - When seen she also had Bronchopneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Lansdowne.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical examination.

(Signed) Daniel M. Stiefel M. D.

, 19 (Address) Lafayette Ave & John St Hosp. for Women of Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL May 30 1922

20 UNDERTAKER Henry W. Hunkins & Sons Co ADDRESS Orchard McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 64690

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 921 Jordan Alley ST.; 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Johnson

(Residence in Baltimore: No. 921 Jordan Alley St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, About (Month) (Day), 1900 (Year)

7-AGE, 22 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto, Md,

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Johnson

(Address) 921 Jordan Alley

15-

Filed ....., 191.....

MAY 2 9 1922

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulm Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

May 29 1922 (Address) 202 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, May 29, 1922

20-UNDERTAKER Hines Earle — ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 64691 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 64691 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 N. Bond St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew McLain

(Residence in Baltimore: No. 419 N. Bond St.; yrs. 52 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Married

6-DATE OF BIRTH. May (Month) (Day) 1870 (Year)

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): — 04

9-BIRTHPLACE. (State or Country) Charlotte N. C.

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER. (State or Country) N. C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice McLain

(Address) 419 N. Bond

15- MAY 29 1922 ROBERT R. KNAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 28 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Splenic Flexura of Colon

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Pollitt M. D. (Coroner.)

May 29 1922 (Address) North Eastern Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Asbury Cem.	May 30 1922

20-UNDERTAKER.	ADDRESS
Christ. Johnson	216 N. Conk

State CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64692

CERTIFICATE OF DEATH.

129 D 64692

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Bloomingdale Road ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Franklin Amos

(a) RESIDENCE NO. 1409 Bloomingdale Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Jane Amos

6 DATE OF BIRTH (month, day, and year) May 22nd, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	-	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman 866

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Packers.

(c) Name of employer Armour & Co.

9 BIRTHPLACE (city or town) (State or country) Harford Co . Md.

PARENTS

10 NAME OF FATHER Zachariah Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline F. Moore.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs Nora J. Amos

(Address) 1409 Bloomingdale Road

15 MAY 29 1922 ROBERT N. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27th, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1922 to May 27 1922.

that I last saw him alive on May 27 1922.

and that death occurred, on the date stated above, at 6.30P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) ✓ yrs ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Olan Beach

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) John A. Thalard M. D.

May 28 1922 (Address) 1219 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL May 30th 22

20 UNDERTAKER Putnam & Gore

ADDRESS 1713 W Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64693 — 14-001 — D 64693

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4103 Ridgewood ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo W. Stinchcomb

(a) RESIDENCE NO. 4103 Ridgewood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Jennie Stinchcomb

6 DATE OF BIRTH (month, day, and year) March 24 1847.

7 AGE	Years	Months	Days	if LESS than 1 day, ..hrs or ..min.
	75	2	3,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Absolem Stinchcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Surviving Isaac

(Address) 4103 Ridgewood Avenue

15 MAY 29 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-22

17 I HEREBY CERTIFY, That I attended deceased from April, 1922, to May 27, 1922, that I last saw him alive on May 27, 1922, and that death occurred, on the date stated above, at 10-20 P. m.

THE CAUSE OF DEATH* was as follows:

Cerebral Hemorhage (Hemiplegia.)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) H. Friedrich, M. D.

5/29 1922 (Address) Main & Hayward Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL May 29 1922

20 UNDERTAKER William Cook — ADDRESS 508 E Northern

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64694 — 001 — 74 — D 64694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 605 Eversham ST., (Evans WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Schofield

(a) RESIDENCE NO. 605 Eversham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Schofield

6 DATE OF BIRTH (month, day, and year) Sept. 26 72

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Nellie Wilson

(Address) 605 Eversham

15 JOHN H. KNAUER, Registrar

MAY 29 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1922, to May 27, 1922, that I last saw h[er] alive on May 27, 1922, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) Wm. O. Pillsbury, M. D.

, 19 (Address) 415 Cedarcroft Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 29 1922
20 UNDERTAKER	ADDRESS
Wm Cook	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64695

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 623 N. Carrollton Ave REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. 623 ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Harrison McCardwell

(Residence in Baltimore: No. 623 N. Carrollton Ave St.; 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Married

6-DATE OF BIRTH, ... (Month) 15 (Day), 1840. (Year)

7-AGE, 81 yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country) Abscott City Md

PARENTS.

10-NAME OF FATHER James L. McCardwell

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER Margaret Calvert

13-BIRTHPLACE OF MOTHER (State or Country), Ellicott City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice McCardwell

(Address) 623 N. Carrollton Ave

15- Filed MAY 29 1922, 191.... J. H. Wilson Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH May (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 23 1922, to May 27 1922, that I saw him alive on May 27 1922, and that death occurred, on the date stated above, at 10:35 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) Bernard Schmidt Moore M. D.

May 28, 1922 (Address) 1037 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery | DATE OF BURIAL, May 29, 1922

20-UNDERTAKER John O. Mitchell | ADDRESS 1301 E. Fayette

CAUSES OF DEATH must be plainly written. Every question must be answered if possible. Omissions cause delay. Be careful and exact. Every statement important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64696

99-002

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 Reservoir ST., 13 WARD)

2-FULL NAME Rebecca S Higgins

(a) RESIDENCE NO. 748 Reservoir ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Higgins

6 DATE OF BIRTH (month, day, and year) Feby 6 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Georgetown (State or country) D. C.

PARENTS

10 NAME OF FATHER Robert O Duld

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Pauline Grither

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jessie Higgins (Address) 748 Reservoir

15 Filed MAY 29 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921 to May 28 1922

that I last saw h alive on May 27-22

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(duration) yrs 7 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J C Hough M. D.

(Address) 1 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 30 1922

20 UNDERTAKER John O Mitchell

ADDRESS 130 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 64697

HEALTH DEPARTMENT—CITY OF BALTIMORE

902 64697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 919 N Carrollton Aven ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mrs Caroline Winchester Miller

(a) RESIDENCE No. 919 N. Carrollton Av. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1853

7 AGE: Years 68 Months 9 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Lady 067

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Island Md

PARENTS

10 NAME OF FATHER Wm H Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Winchester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie M L Miller

(Address) 919 N Carrollton Ave

15 Filed MAY 29 1922 J C Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1921, to May 26, 1922.

that I last saw her alive on May 26, 1922

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chr. Bronchitis and emphysema with dilation of heart cavities and mitral insufficiency

(duration) some 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Sudden Cardiac Syncope

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Robert H. Mifflin, M. D.

May 27 19 22 (Address) 701 N Mad. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 29 1922

20 UNDERTAKER: John O Mitchell — ADDRESS: 120 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64698

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 N Fremont ST., 4 WARD)

2-FULL NAME Mary A. Mallonee

(a) RESIDENCE NO. 307 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): Sept 27. 1883

7 AGE: Years 38 ~~38~~ Months 8 Days 1 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Wisman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jno J. Mallonee

(Address): 307 N Fremont

15 Filed MAY 29 1922 J C Welsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1922, to May 28, 1922, that I last saw h[illegible] alive on May 26, 1922, and that death occurred, on the date stated above, at 2:00 A m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) Geo Hemmeter, M. D.

5-27, 1922 (Address) 800 Harlem Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Walern

DATE OF BURIAL: May 31 1922

ADDRESS

20 UNDERTAKER: John J Fields 1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64699 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64699

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5007 Park Heights Ave St., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Elliott

(a) RESIDENCE NO. 5007 Park Heights Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov 11-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Inspector 386

(b) General nature of industry, business, or establishment in which employed (or employer): Underwriters Assn

(c) Name of employer: Assn Fire Underwriters

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm E. Elliott Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah C. Archer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mark G. Elliott 5007 Park Heights Ave

15 MAY 29 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1922 to May 25, 1922 that I last saw h alive on May 25, 1922 and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Hem Le Gastrectomy
Hy pastrophy of the heart

(duration) 35 yrs. mos ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carl Peters, M. D.

May 26, 1922 (Address) 6 W. Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: May 29 1922

20 UNDERTAKER: Gus. Weber's Son | ADDRESS: 250 3 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64700

D 64700

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Moncure

(a) RESIDENCE. NO. Lutherville, Md ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): X

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) May 26 - 1922

7 AGE — Years — Months — Days

If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Moncure

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Va

12 MAIDEN NAME OF MOTHER Grace Beale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Va.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAY 29 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to May 28, 1922, that I last saw her alive on May 28, 1922, and that death occurred, on the date stated above, at 3 3/4 am.

The CAUSE OF DEATH* was as follows:

prematurity

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) TB Gay. M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bates Cemetery, near Lutherville Md

DATE OF BURIAL: May 29 1922

20 UNDERTAKER: N. E. Hughes

ADDRESS: 1214 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64701

90 D 64701

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 W. Hamilton Ave ST. 27 WARD)

2-FULL NAME William Lewis Fischer

(a) RESIDENCE NO. 8 W. Hamilton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie W. Fischer

6 DATE OF BIRTH (month, day, and year) 1/5/1851

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelright

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmena Wode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Fischer
(Address) 8 W. Hamilton Ave

15 MAY 29 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 26 1922 to May 26 1922

that I last saw h alive on May 26 1922,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis (chronic)
" acute
Myocarditis.

(duration) 3 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Edema of lung

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Exam

(Signed) Orrin C. Pellman M.D.

5/27 1922 (Address) 928 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	5/30 1922
20 UNDERTAKER	ADDRESS
Albert L. Hilt Jr	1606 N Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 64702

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 E. Oliver St ST., 8 WARD)

2-FULL NAME Ernest A. Rittershofer

(a) RESIDENCE NO. 2011 E. Oliver St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Rittershofer

6 DATE OF BIRTH (month, day, and year) 9/1/1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Brushmaker

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Rittershofer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Amelia Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Julia Rittershofer

(Address) 2011 E. Oliver St

15 MAY 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922 to May 28, 1922.

that I last saw him alive on May 28, 1922,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Microscopic

What test confirmed diagnosis?

(Signed) W. L. Hearn, M. D.

May 29, 1922 (Address) 1301 N Pat Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5/31 1922

20 UNDERTAKER Albert L. Hilty Jr

ADDRESS 1606 N Charles St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE and CONDITION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lungs involved.

Heart

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64703

CERTIFICATE OF DEATH.

164 D 64703

1-PLACE OF DEATH North Bend South Ave E of

CITY OF BALTIMORE: (NO. Catonsville ST.: 11 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christena Koerting

(a) RESIDENCE. NO. 816 Madison Av ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of J Henry Koerting

6 DATE OF BIRTH (month, day, and year) March 9 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
81		2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Casper Spiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Jr Fordinbay
(Address) 816 Madison Av

15 MAY 2 9 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 8, 1922, to May 27, 1922, that I last saw h~~er~~ alive on May 26, 1922, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Arsenic Coma 0 0 0

(duration) about 40 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) Long yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) G. Patrick Ecoff, M. D.

5/29, 1922 (Address) 905 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	5-30 1922
20 UNDERTAKER Henry W Deutsch & Sons Co	ADDRESS W Fallsway Corner

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Coma due to senility & not to chronic nephritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

156086
D 64704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 D 64704

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CALHOUN T. LADSON

(a) RESIDENCE. ~~No.~~ ASHEVILLE - N. C. ~~ST.~~, ~~WARD.~~

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): WIDOWED

5a If married, widowed, or divorced HUSBAND of (or, ~~WIFE of~~): MRS PLUME H. LADSON

6 DATE OF BIRTH (month, day, and year): FEB. 28, 1862

7 AGE 60 Years — Months — Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NONE

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER: Francis Ladson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Margaret Brantley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 MAY 29 1922 ROBERT R. KRAUTER. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAY 29 1922

17 I HEREBY CERTIFY, That I attended deceased from MAY 23, 1922, to MAY 29, 1922, that I last saw h.i.m. alive on MAY 28, 1922, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

CHR. PULM. TBC.

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) John L. Dorsey, M. D.

. 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Atlanta Ga.

DATE OF BURIAL: 5-29 1922

20 UNDERTAKER: Harrison Jenkins & Bro Co

ADDRESS: McCullough Atlanta

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last Attendant of Deceased TION is very important. See instructions on back of certificates.

D 64705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64705

CERTIFICATE OF DEATH.

25 90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 101 S. First St. Brooklyn. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Cornelius J. Conner. 45

(Residence in Baltimore: No. 101 S. First St. Brooklyn. St.; yrs...mos...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Widower.

6-DATE OF BIRTH. November 28th. 1854.
(Month) (Day) (Year)

7-AGE. 67 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Letter carrier.
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.S.

9-BIRTHPLACE, (State or Country). Boston, Mass.

PARENTS

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER. (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER. (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willian H. Conner. (son)

(Address) 101 S. First St. Brooklyn.

15-

MAY 29 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 26th. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

May 29th. 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loan Hill Cem	May 30 1922

20-UNDERTAKER. C. Schloman & Son ADDRESS 1039 Hanover

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H.P. Co.—1000 Bks.

See affadavit over

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64706

D 64706

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST. 3 WARD)

2-FULL NAME Maria Palazzo

(a) RESIDENCE. No. 140 Gough St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 2 yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Ferdinando Ned Palazzo

6 DATE OF BIRTH (month, day, and year): June 12 1846

7 AGE: Years 26 Months - Days - If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Santo Scampoli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Vittoria D'Adamo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed ... 19 ... MAY 29 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14 - 1922, to May 27, 1922

that I last saw her alive on May 27 - 1922

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Advanced pulmonary tuberculosis -

Tuberculous pharyngitis and laryngitis

Tuberculous ulceration of intestinal tract

Terminal caseous broncho-pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Under observation for tbc for the past year at J.H.H. Dr. Pleasants

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? yes - partial

What test confirmed diagnosis? -

(Signed) T. H. Cathcart, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: May 30 1922

20 UNDERTAKER: Wendell Dysel & Son

ADDRESS: 373 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Personally appeand before me this 11th day
of December 1923. Mr Nicholas Giardina. who
made affadint that the name on Death Certificate
#= D 64706. should read. Maria Palazzo, ~~Mrs~~ Maria
Scampoli. ~~Husband~~ name should Ferdinando. her father
name should be Santo Scampoli, maiden name of mother sh
be D'Adamo.

Seal Nicholas Giardina

Seal George H Grese
Notary Public

t disease;
ntributory
ed not be
es (disease
a (second-
or terminal
" (merely
ma," "Con-
ile," etc.),
" "Hemor-
" "Shock,"
ite disease
qualify all
arriage, as
eritonitis,"
ration was
MEANS OF
ICIDAL, or
possible to
tal drown-
. Revolver
rbolic acid
injury, as
g., sepsis,
"contribu-
f cause of
clature of

MENTS

Spec.—6-9-19—H. P. Co.—1000 Bks.

64707 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64707

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S. 5th. St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Cordelia Huber

(a) RESIDENCE. No. 412 S. 5th St., 26 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ditto

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER William Huber

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Cushing

13 BIRTHPLACE OF MOTHER (city or town) Cockeysville (State or country) Maryland.

14 Informant Lydia Cushing (Address) 412 S. 5th St.

15 Filed MAY 29 1922, 19.. Registrar ROBERT R. KRAUSER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 28, 1922, that I last saw her alive on May 24, 1922, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

Pelvic abscess drained

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) general debility (was fed)

(duration) ....yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

May 29, 1922 (Address) 1014 S. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	May 29 1922

20 UNDERTAKER Wendell Ruppel & Son ADDRESS 378 Mn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Bohnlofink

HEALTH DEPARTMENT—CITY OF BALTIMORE

64708

CERTIFICATE OF DEATH.

114 D 64708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 228 Belmont Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bohnlofink.

(a) RESIDENCE NO. 1228 Belmont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Bohnlofink

6 DATE OF BIRTH (month, day, and year): Aug 22 1855

7 AGE: Years 66 Months 9 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 088

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Bohnlofink

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Louisa Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Barbara Bohnlofink (Address) 1228 Belmont Ave

15 MAY 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Jany 5th 22, 19, to May 27 19 22.

that I last saw him alive on May 26th 22, 19

and that death occurred, on the date stated above, at 5.10 a m.

The CAUSE OF DEATH* was as follows:

Uremia Catarrhal Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. Chr mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno. F. Lyles M. D.

19 (Address) 801 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 30 1922

20 UNDERTAKER: John Ullrich

ADDRESS: 200 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143-002

D 64709

REGISTERED NO. D 64709

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. Monument St. Rutland ave WARD 03)

2-FULL NAME Mrs. Louisa Weidermann

(a) RESIDENCE. NO. 1104 S. Sharp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Theodore Weidermann

6 DATE OF BIRTH (month, day, and year) Sept 5, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~39~~	38	8	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home wife H.W. 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Kewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theodore Weidermann
(Address) 1104 S Sharp St

15 Filed MAY 29 1922

ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1922, to May 27, 1922, that I last saw her alive on May 27, 1922, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ectopic gestation sac ruptured (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 26, 1922

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Lacks, M. D.

, 19 (Address) Hebrew Hospital, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL May 30 1922

20 UNDERTAKER J. Ellerick

ADDRESS 200 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64710

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. B

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., WARD)

2-FULL NAME Baby Palazzo

(a) RESIDENCE NO. 1401 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) May 19, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or 29 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Fred Palazzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Scamph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to May 19, 1922, that I last saw him alive on May 19, 1922, and that death occurred, on the date stated above, at 3.25 p m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. H. Cuthrell, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Communicated Health, MAY 2 1922

Dr. Wm. T. WOODALL.

MATION should be entirely supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64711

CERTIFICATE OF DEATH.

32 D 64711

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 10 WARD)

2-FULL NAME Rose Thomas

(a) RESIDENCE No. 1819 Hagers Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 19, 19 22. to May 25, 19 22.

that I last saw her alive on May 25, 19 22.,

and that death occurred, on the date stated above, at 9:40 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ..... yrs. ..... mos. 1 ..... ds. 4

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Tubercle bacilli in CSF.

(Signed) Clyde M. Snell, M. D.

5/25/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Cremation Dept. of Health.

ADDRESS MAY 20 1922

For. Wm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64712

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64712

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gardner

(a) RESIDENCE No. Levering House ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 650

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) Municipal Hospital

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 19 22

17

I HEREBY CERTIFY, That I attended deceased from May 25, 19 22, to May 25, 19 22, that I last saw him alive on May 25, 19 22, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No N.P.H. Unwitnessed

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

5/26/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAY 29 1922

Per. Wm. F. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

81

Spec.—1-10-21—M&T—1500 Bks.

D 64713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64713

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baldwin St. Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Barnes

(a) RESIDENCE NO. 114 W. Hamilton Av. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W.M. F. Barnes

6 DATE OF BIRTH (month, day, and year): July 2 1885

7 AGE: Years 36 Months 10 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Thos. Edward

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Morford McClary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mr. Malcolm Edwards
(Address): 114 W. Hamilton Ave

15 Filed MAY 9 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/9 — 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-6-22, 19 , to May 9, 19 22,

that I last saw h alive on May 9, 19 22

and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Chronic Interstitial Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenwood Cemetery

DATE OF BURIAL: May 11 1922

20 UNDERTAKER: Scott M. Starr

ADDRESS: Fairfield Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64714

CERTIFICATE OF DEATH.

44 D 64714

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Madison Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Washington Bowie

(a) RESIDENCE. NO. 1403 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: K. Poole Gaither

6 DATE OF BIRTH (month, day, and year): July 12 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Librarian 086

(b) General nature of industry, business, or establishment in which employed (or employer): Law Library

(c) Name of employer: Fidelity & Deposit Co

9 BIRTHPLACE (city or town) (State or country): Montgomery Co Md

PARENTS

10 NAME OF FATHER: Thos. John Bowie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Montgomery Co Md

12 MAIDEN NAME OF MOTHER: Catherine Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Montgomery Co Md

14 Informant (Address): Washington Bowie 14 & Fidelity Bldg City

15 Filed MAY 29 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/28 1922

17 I HEREBY CERTIFY, That I attended deceased from 2/3/22, 19..., to 5/28/22, 19..., that I last saw h... alive on 5/27, 1922, and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Cancer of Stomach

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. H. Wiemuth, M. D.

5/29, 19... (Address) 1302 N. Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	May 30th 1922
20 UNDERTAKER: Henry W. Jenkins & Sons Co	ADDRESS: Orchard & McCulloh Sts

Spec.—1-10-21—M&T—1560 Bks.

D 64715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64715

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 872½ Pierce St ST., 18 WARD)

2-FULL NAME Delia Monroe

(a) RESIDENCE No. 872½ Pierce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .... min.
	65	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Harford Co (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Fannie Howard (Address) 872½ Pierce St

15 Filed MAY 29 1922 19 .... LLS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922 to May 25, 1922, that I last saw her alive on May 24, 1922, and that death occurred, on the date stated above, at 6.45 A.m.

The CAUSE OF DEATH* was as follows:

apoplexy
Bright Disease & Complication of Disease

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Bright Disease & Complication Disease (duration) ..... yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wright Kennard M. D.

5-26, 1922 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lion — DATE OF BURIAL May 29 1922

20 UNDERTAKER Edward Quiggold — ADDRESS 1463 Carey

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64716

D 64716

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 N. Kylie Ave ST., 15 WARD)

2-FULL NAME Ada J. King

(a) RESIDENCE NO. 6 N. Kylid Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: A. J. King

6 DATE OF BIRTH (month, day, and year): Jan. 29-1858

7 AGE — Years: 64 Months: 3 Days: 29 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard Co. Maryland

PARENTS

10 NAME OF FATHER: Capt. R. H. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): A. J. King 16 N. Kylie Ave

15 MAY 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Mch 2, 1922 to May 28, 1922.

that I last saw h[illegible] alive on May 27, 1922,

and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia (duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Colin Murray, M. D.

May 26, 1922 (Address) 1721 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: May 31 1922

UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Falls Rd.

Sec.—6-9-19—H. P. Co.—1000 Bks.

155 897

HEALTH DEPARTMENT—CITY OF BALTIMORE

139

D 64717

CERTIFICATE OF DEATH.

D 64717

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Manns

(a) RESIDENCE. No. Fairfield, Md ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 Unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced (or) WIFE of John Manns

6 DATE OF BIRTH (month, day, and year) March 12 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	2½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Henderson Bradshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant JOHNS HOPKINS HOSPITAL, (Address)

15 MAY 9 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14 -, 1922, to May 27 1922, that I last saw h.. alive on May 27, 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Part I Intestinal obstruction, probably

operation to relieve obstruction

patient dying on operating table.

(duration) yrs. mos. 2 3 ds.

CONTRIBUTORY (Secondary) Pernicious Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. H. Metcalf, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL May 30 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hysterectomy.
for benign tumor
of uterus. Myoma.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 64718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64718

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rella Michael

(a) RESIDENCE. NO. 1900 Bayard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frederick Michael

6 DATE OF BIRTH (month, day, and year) Jan 14. 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	4	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Jacob A Rankle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Burkle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Fredrick Michael

(Address) 1900 Bayard St.

Robert P. Harrison,

Y 2 9 1922 . 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922.

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1922, to May 28, 1922, that I last saw her alive on May 28, 1922, and that death occurred, on the date stated above, at 1.08 P m.

The CAUSE OF DEATH* was as follows:

Plastic Peritonitis
Left Salpingitis
General Septicemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Toxemia - Cardiac Failure. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1900 Bayard St

Did an operation precede death? Yes Date of May 24, 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Whitehead, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 30 1922
20 UNDERTAKER	ADDRESS
Geo Leuerbach & Son	647 W Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Gonococcus Infection

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64719

D 64719

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rosa Frost.

(a) RESIDENCE NO. 2543 Mc Henry St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Frost

6 DATE OF BIRTH (month, day, and year) ? ? 1854

7 AGE Years 63 yrs. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know Switzerland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant John Frost (Address) 2543 Mc Henry St.

15 MAY 29 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26 1922.

17 I HEREBY CERTIFY, That I attended deceased from 5-24, 1922, to 5-26, 1922.

that I last saw H. alive on 5-26, 1922

and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus -

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Clinical-Laboratory

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL May 30th 1922

20 UNDERTAKER Geo Leimbach & Son — ADDRESS 647 W Pratt St

BEFORE signing, the person who will sign the CERTIFICATE OF DEATH should be asked to read it carefully. AGE should be stated EXACTLY. PHYSICIAN writing CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

11777 D 64720

HEALTH DEPARTMENT—CITY OF BALTIMORE D 64720

CERTIFICATE OF DEATH STILL BIRTH No. 11777

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 114 S Calvert St.) 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dwyer

(a) RESIDENCE NO. 114 S. Calvert St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, 8 hrs. or 55 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John P. Dwyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Marie C. Bothe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs J. P. Dwyer 114 S. Calvert St

15 Filed MAY 29 1922 J E Weber Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1922, to May 28, 1922, that I last saw her alive on May 28, 1922, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(7 mos)

(duration) yrs. mos. 55 days

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M L O'Neill M. D.

May 28 1922 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 29 1922

20 UNDERTAKER: George L. Schwab — ADDRESS: 110 Park Ave

REASON should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64721

CERTIFICATE OF DEATH.

165

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 W North Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary Loretta Ridin

(Residence in Baltimore: No. 607 W North Ave St.; yrs. 4 mos. ds.)

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Nov. (Month) 1 (Day) 55 (Year)

7-AGE: 66 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Patrick Ward.

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Anna Smith

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Barrett

(Address) 2406 E Baltimore St.

15- Robert P. Harrison,

Filed ..... 192 ..... Registrar.

Burial Permit Clerk.

1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poison

Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner.)

(Address) 7632 Roland Ave

1922

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Mar 30 1922

20-UNDERTAKER: Wm Cook — ADDRESS: [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64722

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64722

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Apts. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kelso Wilson.

(a) RESIDENCE. No. University Apts. ST., 12 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? 69 yrs. 10 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bertrand Wilson

6 DATE OF BIRTH (month, day, and year) July-18-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer's A'g't.

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware.

(c) Name of employer (self)

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Dr. Henry M. Wilson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Kelso.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant John K. Wilson Jr., (son) (Address) Lombardy Apts., City.

15 [illegible] 19 [illegible] Registrar

MAY 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 192[illegible]

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1922, to May 28, 1922, that I last saw h[illegible] alive on May 28, 1922, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Stokes - Adams disease

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George H. Bon, M. D.

, 19 (Address) 1005 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY	MAY-31-22

20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODS, [illegible])	108 W. NORTH AVE

Burial Permit Mark.

mation should be carefully supplied. AGE should be stated EXACTLY. P
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exac.. statement of C
TION is very important. See instructions on back of certificates.

D 64723

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 64723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Jos. Hospital) (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M Dahl.

(Residence in Baltimore: No. 1. Wilson Terrace St.; 4 yrs.) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Dec. 1st, 1863
(Month) (Day) (Year)

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Norway

PARENTS.

10-NAME OF FATHER, Dahl

11-BIRTHPLACE OF FATHER (State or Country), Norway

12-MAIDEN NAME OF MOTHER Andersen

13-BIRTHPLACE OF MOTHER (State or Country), Norway

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Randi Dahl

(Address) 1 Wilson Heights

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

2 9 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and by (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Fall off scaffold

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Ross Jamison (Coroner)

5-27-1922 (Address) Epidemiologist

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL, 5-30, 1922

20-UNDERTAKER J. J. Moran

ADDRESS 300 E Watson

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64724

CERTIFICATE OF DEATH.

1595 D 64724

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 4 Franklin ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel M Ambrose

(a) RESIDENCE No. 1602 4 Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 26/1922

7 AGE: Years | Months | Days: 3 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 900

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm L Ambrose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Reba L Riall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: William L Ambrose (Address) 1602 4 Franklin St

15 Filed ..... 19 ..... Registrar

MAY 2 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to May 24, 1922, that I last saw h[illegible] alive on May 24 1922 and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Improper circulation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clark M. D.

(Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: May 30 1922

20 UNDERTAKER: William Cook ADDRESS: 502 E Mulberry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64725

CERTIFICATE OF DEATH.

13 / D 64725

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1723 Webster ST.: 24 WARD)

2-FULL NAME Ada E Watford

(a) RESIDENCE. No. 1723 Webster ST., 23 WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Isaac Watford

6 DATE OF BIRTH (month, day, and year) July 11 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co Md

PARENTS

10 NAME OF FATHER Craig Branch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queen Anne Co Md

12 MAIDEN NAME OF MOTHER Virginia Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Anne Co Md

14 Informant Mrs Ada Watford

(Address) 1723 Webster St

15 MAY 3 01922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from 10/15/21, to 5/28/22, that I last saw her alive on 5/28/22, and that death occurred, on the date stated above, at 1:50 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) 11

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James Brown, M. D.

. 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	May 31 1922
20 UNDERTAKER	ADDRESS
Mrs J E Evans & Sons	1420 S Charles

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64726

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 D 64726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 Mt. Cullough St., ST.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Morgan

(Residence in Baltimore: No. 1114 Mt. Cullough St. lived in Balt- 4 years St.; yrs., 13 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, about (Month) (Day), 1891 (Year)

7-AGE, 31 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework, 837
(b) General nature of industry, business, or establishment in which employed (or employer): House Work

9-BIRTHPLACE, (State or Country): Norfolk, Va.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country): unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Johnson

(Address) 1129 Druid Hill Ave

15-

FILED MAY 30 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry), thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Metastatic Carcinoma)

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

May 29, 1922 (Address) 2102 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, May 30, 1922

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12157 D 64727 — D 64727

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanie Edwards

(a) RESIDENCE. No. North Eutaw St., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER June King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Betsy Keffee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 MAY 8 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26th, 1922, to May 28th, 1922, that I last saw h.e alive on May 28th, 1922, and that death occurred, on the date stated above, at 11:55 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, hypertension, myocardial insufficiency.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, acute

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. Sidney Burwell, M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Entaria Co	May 30 1922
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64728

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ridge Road ST., 27 WARD)

2-FULL NAME Isaac B. Stonebraker

(a) RESIDENCE NO. Ridge Road Int Washington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Jos R. Stonebraker

6 DATE OF BIRTH (month, day, and year) 5. 4. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Boiling Spring
(State or country) Cumberland Co Penna

PARENTS

10 NAME OF FATHER Abram Boyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Herman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant James B. Stonebraker
(Address) Int Washington

15 MAY 3 01922 ROBERT R. JACKTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1922, to May 28, 1922, that I last saw h[illegible] alive on May 28, 1922, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Senile degeneration - Initial Regurgitation - Chronic Bright - Anemia - Exhaustion

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood - Urine -

(Signed) C. H. Bellem M. D.

5.28. 192 (Address) Int Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: May 31 1922

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 N. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 64729

D 64729

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital, St.: 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Turner

(a) RESIDENCE. No. Unknown St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse 048

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dayton, Ohio.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed MAY 30 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to May 26, 1922, that I last saw her alive on May 26, 1922, and that death occurred, on the date stated above, at 10:10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic arthritis (duration) / yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

5/29/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means And Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: May 30 1922

20 UNDERTAKER: MR. & MRS. N. S. FINK, FUNERAL DIRECTORS — ADDRESS: 1835 W. PRATT STREET.

Duplicate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64730 HEALTH DEPARTMENT—CITY OF BALTIMORE

3 / D 64730

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Druid Hill Ave ST.) 14 WARD)

2-FULL NAME Ernest Vrooman

(a) RESIDENCE. NO. 1006 Druid Hill Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Died

6 DATE OF BIRTH (month, day, and year) Aug 13 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ernest Vrooman

11 BIRTHPLACE OF FATHER (city or town) Robinson (State or country) Nebraska

12 MAIDEN NAME OF MOTHER Mabel Johnson

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) DC

14 Informant Father - Ernest Vrooman

(Address) 1006 Druid Hill Ave

15 Filed MAY 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 22

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to May 29, 1922, that I last saw him alive on May 28, 1922, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis (Pulmonary)

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Tuberculin Meninges

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Edwin Chenoweth, M. D.

5/29 1922 (Address) 1438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL May 31 1922

20 UNDERTAKER John H. Toadvine ADDRESS 142 W. Hoffman St

Spec.—1-10-21—M&T—1500 Bks.

Bowman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64731

CERTIFICATE OF DEATH.

117

D 64731

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913-N Calhoun St., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite Bowman

(a) RESIDENCE NO. 913-N Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Repd

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June - 1910

7 AGE: Years 11 | Months 11 | Days 28 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Mary's Co. Md

12 MAIDEN NAME OF MOTHER: Bertha Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Jennie R. Bowman (Sister)

(Address) 913-N Calhoun St

15 MAY 3 01922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 28, 1922, that I last saw her alive on May 28, 1922, and that death occurred, on the date stated above, at 12.45 p.m.

The CAUSE OF DEATH* was as follows:

Acut Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Acut Appendicitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Dr. Blore's office

Did an operation precede death? No Date of

Was there an autopsy? Typical Symptoms

What test confirmed diagnosis:

(Signed) Wells A. Peters M. D.

19 (Address) 618 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: May 30 1922

20 UNDERTAKER: Edward Ruggold — ADDRESS: 1463 Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64732

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 11 White Ave. St.; Hamilton 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Catharine Schwesinger

(Residence in Baltimore: No. 11 White Ave St.; abt 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, ~~Jan~~ ~~25~~ ~~29~~, 1862
(Month) (Day) (Year)

7-AGE, 60 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Conrad Schaffer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Josephine Moore

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Schwesinger

(Address) 11 White Ave.

15- MAY 3 1922 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 27 1922, to May 29 1922, that I saw her alive on May 28 1922, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

a. .....

b. Diabetes Mellitus

c. .....

(Duration) Months Days.

CONTRIBUTORY (Secondary) Nephritis

(Duration) Months Days.

(Signed) Percy Krauter M. D.

May 30, 1922 (Address) 2507 N Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, June 1, 1922.

20-UNDERTAKER E. LeRoy Stifflen ADDRESS 125 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64733

CERTIFICATE OF DEATH.

46

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 E. Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Skudrna

(a) RESIDENCE. No. 2002 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Skudrna

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frank Skudrna (Address) 2002 E. Madison St.

15 Filed MAY 31 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922 to May 28, 1922, that I last saw her alive on May 27, 1922, and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac Calculation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) M. Mahoney, M. D.

5-30-1922 (Address) 800 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 31 1922

20 UNDERTAKER: Frank Smith Sons — ADDRESS: 1916 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64734

CERTIFICATE OF DEATH.

117 D 64734

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. Mary Berchmans Gough

(a) RESIDENCE NO. Mercy Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1843

7 AGE: Years 79; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer): 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mercy Hospital Records

(Address)

15 Filed MAY 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1922, to May 30, 1922, that I last saw her alive on May 30, 1922, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Appendicial abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia, Cystitis and Cardiac failure (duration) yrs. 1 mos. 16 ds.

18 Where was disease contracted if not at place of death? Opening & drainage abscess

Did an operation precede death? yes Date of Apr 26, 1922

Was there an autopsy? no

What test confirmed diagnosis? Findings of Physical Signs

(Signed) John J Carey, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt St Agnes Private Ground — DATE OF BURIAL: May 31 1922

20 UNDERTAKER: Henry W Jenkins Sons Co — ADDRESS: Orchard & Collins Sts

Spec.—6-3-19—H. P. Co.—1000 Bks.

D 64735 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64735

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Athol Ave (near Frederick Road) ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo F. Heubeck

(a) RESIDENCE. NO. Athol Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? 75 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widowed

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~Wife~~ of Christina St. Heubeck

6 DATE OF BIRTH (month, day, and year) March 9, 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 059

(b) General nature of industry, business, or establishment in which employed (or employer) Geo F. Heubeck & Son

(c) Name of employer Plumbers

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Heubeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Stulenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Walter Kuttf Athol Ave

15 Filed MAY 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1922, to May 30, 1922; that I last saw him alive on May 30, 1922; and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Oedema Pulmonum of not less than 12 hours.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anuria of probably 4 or 5 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? NO. Date of X

Was there an autopsy? NO. Were findings known? Auscultation; Percussion

What test confirmed diagnosis?

(Signed) Eclaire C. Price, M. D.

MAY 30 1922 (Address) 101 E. Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL JUN 1 1922

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D64736 HEALTH DEPARTMENT—CITY OF BALTIMORE D64736

CERTIFICATE OF DEATH. 160

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hosp. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rita Helen Kalb

(Residence in Baltimore: No. Washington Ave, Towson Md St.; yrs.....mos.....ds.)

Towson

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. May (Month) 3 (Day) 1922 (Year)

7-AGE, ...yrs. .....mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Office

9-BIRTHPLACE, (State or Country). Towson Md

PARENTS.

10-NAME OF FATHER. John L B Kalb

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore City Md

12-MAIDEN NAME OF MOTHER. Mary O Brien

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Burns Sons

(Address) Towson Md

15- Filed 5/31/22. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 30 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mal Nutrition

cause not determined

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Tatem M. D.

(Coroner.)

May 31 1922. (Address) 508 E Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Prospect Hill Cem	June 1, 1922
20-UNDERTAKER. John Burns Sons	ADDRESS Towson

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64736

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Helen Kalb.

(a) RESIDENCE. NO. Towson Md ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced (HUSBAND of) (or) (WIFE of) —

6 DATE OF BIRTH (month, day, and year) May 3 1922

7 AGE — Years ~~11~~ Months Days 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Towson Md

PARENTS

10 NAME OF FATHER John. F. B. Kalb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City

12 MAIDEN NAME OF MOTHER Mary Bryan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar
MAY 31 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30- 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30- 1922, to May 30- 1922, that I last saw her alive on May 30th 1922, and that death occurred, on the date stated above, at 6- P. m.

The CAUSE OF DEATH* was as follows:

Hereditary syphilis — (Suspected)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ....yrs. unknown mos. ....ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Wassermann not reported yet

(Signed) Horace G. Stewart. M. D.

5/30, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill — DATE OF BURIAL: June 1 1922

20 UNDERTAKER: John Burns Sons — ADDRESS: Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 64737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64737

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 W. North St. Ave 13 WARD)

2-FULL NAME Nathan Rosenthal

(a) RESIDENCE NO. 1126 W. North Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie Rosenthal

6 DATE OF BIRTH (month, day, and year) July 4 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Abraham Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Zeisig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Sam. Rosenthal (Address) 1126 W. North Ave

15 Filed MAY 31 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1919 to May 29, 1922

that I last saw him alive on May 28, 1922

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gpine. Gram.

(Signed) Louis P. Hamburger M. D.

(Address) 1207 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Heb. Friendship Cem. DATE OF BURIAL 5/31/1922

20 UNDERTAKER David Londheim ADDRESS 115 N. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64738

CERTIFICATE OF DEATH.

173 D 64738

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. 1514 Division Street ST. 14 WARD)

2-FULL NAME Mrs. Jacob Hable (Cecelia)

(a) RESIDENCE. NO. 2064 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr. Jacob Hable

6 DATE OF BIRTH (month, day, and year) 12-7-1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Henry Hecla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Hable (Address) 2064 Linden Ave

15 Filed MAY 31 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31-1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to May 31, 1922, that I last saw her alive on May 31, 1922, and that death occurred, on the date stated above, at 3.25 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency, which became evidenced about 2 wks after operation

(duration) yrs. mos. 15-16 ds.

CONTRIBUTORY (Secondary) Stones in and inflammation of Common duct (duration) yrs. 2 mos. ? ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Apr. 29, 22

Was there an autopsy? No

What test confirmed diagnosis? Operation - Choledochotomy

(Signed) Paul W. Sutton, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem

DATE OF BURIAL: 6/1/22 19

20 UNDERTAKER: David Sondheim ADDRESS 1180 McHenry Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64739

D 64739

CERTIFICATE OF DEATH.

89

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Caroline St. WARD)

2-FULL NAME Abraham Diamond

(a) RESIDENCE NO. 217 N. Caroline St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 31 yrs. ... mos. ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Diamond

6 DATE OF BIRTH (month, day, and year) Russia

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Selig Diamond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fagie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1739 E Balto St

15 Filed MAY 3 1 1922 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1922

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to May 30, 1922

that I last saw h alive on May 30, 1922

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? observation of attd

(Signed) Joseph Elgin, M. D.

May 31 1922 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Sinai Rosedale — DATE OF BURIAL May 31 1922

20 UNDERTAKER East Lawn, ADDRESS 1439 E Balto St.

Spec.—1-10-21—M&T—1500 Bks.

D 64740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64740

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N. Pine ST., 17 WARD)

2-FULL NAME Sarah May Burton

(a) RESIDENCE NO. 428 N. Pine ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, with ink. Use no abbreviations. Fill in ALL blanks. Data must conform EXACTLY with the entries on the certificate of birth. Omission of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 18 1922

7 AGE — Years: ~~4~~ Months: 4 Days: 18 — If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Edward T. Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Halligan Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Hallagan Burton

15 MAY 31 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/29/1922

17 I HEREBY CERTIFY, That I attended deceased from 5/29, 1922, to 5/29, 1922

that I last saw h alive on 5/29, 1922

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Stenosis 2 hours

acute (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis about 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

5/30/22 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: May 31 1922

20 UNDERTAKER: Samuel Brawley

ADDRESS: Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 64741 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64741

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Gunther

(a) RESIDENCE NO. 741 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker p 83

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed MAY 31 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 22, 19 22, to May 28, 19 22, that I last saw h im alive on May 27, 19 22, and that death occurred, on the date stated above, at 9:15 A. M.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma of tongue with Metastasis to neck

Exhaustion (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Brumbach, M. D.

5/29/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel. DATE OF BURIAL 5/31-22 19

20 UNDERTAKER Bernard G Feinblatt ADDRESS East Pleasant and

D 64742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64742

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 N. Wolfe St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Becker (better known as Kramer)

(Residence in Baltimore: No. 2725 E. Madison St.; yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. May 18 1907
(Month) (Day) (Year)

7-AGE. 21 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Ex. Penn RR 073
(b) General nature of industry, business, or establishment in which employed (or employer). Power House

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. August C. Becker

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Sophia Kramer

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia (Kramer) Manson

(Address) 2725 E. Madison St.

15- MAY 31 1922 Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 29 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Patton M. D.
(Coroner.)

May 29 1922. (Address) 505 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL. June 2 1922

20-UNDERTAKER. Philip Hennig

ADDRESS 2016 Aisquith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64743

CERTIFICATE OF DEATH.

44 D 64743

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Dover ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Tyler

(a) RESIDENCE. No. 630 Dover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Col	Male	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Tyler

6 DATE OF BIRTH (month, day, and year) June 10-1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45 yrs	~~9 mos~~	~~10 ds~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

074

9 BIRTHPLACE (city or town) (State or country) West River Md

PARENTS

10 NAME OF FATHER Washington Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) West River Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Eliza Tyler

(Address) 630 Dover St

15 Filed MAY 31 1922 19 ROBERT [illegible]

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 31, 1922, to May 27, 1922, that I last saw him alive on May 26, 1922, and that death occurred, on the date stated above, at 11.40 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examined

(Signed) Molly Stong, M. D.

5-29-1922 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery DATE OF BURIAL May 31 1922

20 UNDERTAKER Mc Geo H Hooper ADDRESS 406 N. Conway St

D 64744

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 64744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1931 Asquith St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Juanita Cole

(Residence in Baltimore: No. 1931 Asquith St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed or Divorced, (Write the word.): Single

6-DATE OF BIRTH: May (Month) 17 (Day) 1921 (Year)

7-AGE: 1 yrs. mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Raymond Cole

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Addie Williams

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Cole

(Address) 1931 Asquith St

15-

Filed MAY 31 1922 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 29 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Pattison M. D. (Coroner.)

May 29 1922 (Address) So. & E. Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	May 31 1922
20-UNDERTAKER.	ADDRESS
Mrs. R. A. Elliott	1725 Oakland Ave

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64745

CERTIFICATE OF DEATH.

90 D 64745

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Etting ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Pitts

(a) RESIDENCE NO. 1717 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	5	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John Pitts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ida Boyd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant John Pitts
(Address) 1717 Etting St

15 Filed MAY 31 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1922

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to May 29, 1922, that I last saw her alive on May 29, 1922 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

St. Vitus Dance
(Chorea)

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

5/29, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 31 1922

20 UNDERTAKER Barnett & Speight

ADDRESS 1649 Mad

N. B.—WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64746

CERTIFICATE OF DEATH.

90 D 64746

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 502 S Eutaw ST.; VV WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Martha Naylor

(Residence in Baltimore: No. 502 S. Eutaw St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) April (Day) 2, (Year) 1854

7-AGE, 67 yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Store 045

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper

9-BIRTHPLACE, (State or Country) Lancaster Pa

PARENTS.

10-NAME OF FATHER, John Griffith

11-BIRTHPLACE OF FATHER (State or Country) Lancaster Pa

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Lancaster Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. J. Carrick

(Address) 8-E-Cross St

15-

Filed MAY 31 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit (illegible)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25 1922, to May 27 1922, that I saw h er alive on May 27 1922 and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of the Heart

Do not Know (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Carrick M. D.

May 28, 1922 (Address) 502 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, May 31, 1922

20-UNDERTAKER Millard Cook

ADDRESS 502 E North

I.B. Every question in this certificate should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1 10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64747

REGISTERED NO. D 64747

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 15 E. Lafayette Ave ST., 17 WARD)

2-FULL NAME Frank J. Applegate

(a) RESIDENCE NO. 15 E. Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion E. Applegate

6 DATE OF BIRTH (month, day, and year) Aug 3/1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	42	9	26.	

8 OCCUPATION OF DECEASED 030

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry G. Miller

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Frank Applegate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Marion E. Applegate (Address) 15 E. Lafayette Ave

15 Filed MAY 3 1922 ROBERT N. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1922 to May 29, 1922, that I last saw him alive on May 19, 1922, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(dutation) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arthur E. Beaven M.D.

5/30, 1922 (Address) 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount St Mary's Cemetery DATE OF BURIAL Jun 1, 1922

20 UNDERTAKER William Cook ADDRESS 502 E. North

IMPORTANT: NO CERTIFICATE OF DEATH WILL BE ISSUED UNLESS THIS PERMANENT RECORD is carefully filled in. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64748

CERTIFICATE OF DEATH.

5 179

D 64748

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 800 N. Front ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Dales

(a) RESIDENCE. No. 800 N. Front ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: colored
5 Single, Married, Widowed, or Divorced (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Hanson Dales

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lunenberg Co. Va.

PARENTS
10 NAME OF FATHER: Thomas Taylor
11 BIRTHPLACE OF FATHER (city or town) (State or country): Lunenberg Co. Va.
12 MAIDEN NAME OF MOTHER: Susan Organ
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lunenberg Co. Va

14 Informant: Robert Smithson
(Address): 800 N. Front st.

15 Filed MAY 31 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to May 28, 1922
that I last saw her alive on May 27, 1922
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
(duration) yrs. 4 mos. dy.
CONTRIBUTORY (Secondary): subacute bronchitis
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto Md
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. M. O'Robinson M. D.
5/29/22 (Address) 520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery
DATE OF BURIAL: May 31 1922

20 UNDERTAKER: Clement Hall
ADDRESS: 909 Hillen.

A. B. C. (Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

D 64749

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18-003
18 D 64749

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Myrtle Boston

(Residence in Baltimore: No. 1217 Raburn St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. ..... Jan (Month) ..... 11 (Day) ..... 1917 (Year)

7-AGE. ..... 5 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Balto. City

PARENTS.

10-NAME OF FATHER, Joseph Boston

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER, Georgia Thomas

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgia Thomas

(Address) 1217 Raburn St

15-

Filed MAY 31 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) ..... 27 (Day) ..... 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull & Hemorrhage into Brain Automobile accident

(Duration) .....yrs. .....mos. 1/2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) James McPeters M. D. (Coroner.)

Aug. 29. 1922 (Address) 700 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)
At place of death.....yrs.....mos. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Carrollton Ave & Raburn St

Former or usual residence. 1217 Raburn St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Mar 31 1922

20-UNDERTAKER, Daniel Easton — ADDRESS 916 Rear

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64750

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 N. Fayette ST. 19 WARD)

2-FULL NAME Walter Hollar Galloway

(a) RESIDENCE. No. 1629 N. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If ~~married, widowed or divorced~~ HUSBAND of (or) ~~WIFE~~ of Mary Low Galloway

6 DATE OF BIRTH (month, day, and year) March 3rd, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Fireman 032

(b) General nature of industry, business, or establishment in which employed (or employer) City Fire Dept.

(c) Name of employer Balto. City Fire Dept

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Garret Galloway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salem, Md.

12 MAIDEN NAME OF MOTHER Regina Catherine Hollar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gardenville, Md.

14 Informant Howard Galloway
(Address) 1643 N. Smallwood St

15 Filed MAY 3 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27th 1922 to May 28th 1922 that I last saw him alive on May 28th 1922, and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Unknown (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute dilatation of Stomach (duration) ....yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Fay, M. D.

. 19 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: May 31 1922

20 UNDERTAKER: Daniel Easton — ADDRESS: 916 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64751

101-001 D 64751

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Shield Al ST.: 17 WARD)

2-FULL NAME William Henson.

(a) RESIDENCE. No. 1005 Shield ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Henson

6 DATE OF BIRTH (month, day, and year): Apr 17 1877

7 AGE: Years 45 | Months one | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Helper on Furniture Wagon.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Barnett & Hall.

9 BIRTHPLACE (city or town) (State or country): Howard Co Md

PARENTS

10 NAME OF FATHER: Chas Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant (Address): Howard Henson 1005 Shield Al.

15 Filed MAY 31 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to May 29, 1922, that I last saw h[illegible] alive on May 28, 1922, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) H. E. Linck, M. D.

May 29-1922 (Address) 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery

DATE OF BURIAL: May 31 1922

20 UNDERTAKER: James H. Lewis

ADDRESS: 1313 Pennsylvania Ave

A. B.—MAKE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64752

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 111 Montebello Terrace St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Alfred Wm Kraft

(Residence in Baltimore: No. 111 Montebello Terrace St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: July (Month) 17 (Day) 1905 (Year)

7-AGE: 16 yrs. 10 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): pd

9-BIRTHPLACE, (State or Country): Balto City Md

PARENTS:

10-NAME OF FATHER: John Chas Kraft

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Frieda Lucia Schiller

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C Kraft

(Address) 111 Montebello Terrace

15-

Filed MAY 31 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 29 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hanging Suicide

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Paul M. D.
(Coroner)

May 29 1922 (Address) 708 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: June 1st 1922

20-UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument st

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 64753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64753

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Sinclair Lane ST.: 8 WARD)

2-FULL NAME Elmita Ford

(a) RESIDENCE. NO. 2115 Sinclair Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Ford

6 DATE OF BIRTH (month, day, and year) June 26, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thos R. Germon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Josephine Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant: Elias E Nelson
(Address) 2116 Sinclair Lane

15 Filed MAY 31 1922 19 ROBERT R. KRAUTER (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to May 30, 1922, that I last saw h alive on May 29, 1922, and that death occurred, on the date stated above, at 12.35-A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Frohn, M. D.

5/30 1922 (Address) 1823 N. East Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 1, 1922
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of NEPHRITIS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Comegys)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64754

D 64754

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH Church Home & Inf

CITY OF BALTIMORE: (NO. Broadway Fairmount ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss. Indiana Comegys.

(a) RESIDENCE NO. Church Home & Infirmary ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6 - 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	88	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil County, Md.

PARENTS

10 NAME OF FATHER John Ward Comegys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann M. Comegys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Margaret L. Comegys

(Address) 3126 Q St. N.W. Wash. D.C.

15 Filed MAY 31 1922 MAY 31 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1921, to May 29, 1922.

that I last saw her alive on May 28, 1922.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy Concentric

Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Method

(Signed) Cajetan Paulucci, M. D.

May 30, 1922 (Address) Churchhome Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 31st 1922

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Bal St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64755

CERTIFICATE OF DEATH.

24 170

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Johnson. 50

(Residence in Baltimore: No. 1473 Stevenson St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Single

6-DATE OF BIRTH. Do not know. (Month) (Day) 1..... (Year)

7-AGE, 86 yrs. mos. ds. If LESS than 1 day, ...hrs. or. ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Seaman.

086

9-BIRTHPLACE, (State or Country). Sweden.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Peterson.

(Address) 1473 Stevenson St.

15- UNIVERSITY OF MARYLAND

Filed ..... 192.... ROBERT R. KRAUER, Registrar.

MAY 3 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14th. 1922. (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Due to a pistol shot wound in the Abdomen. Suicide.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Otto F. Reinhardt M. D. (Coroner.)

May 29th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

1473 Stevenson St. May 14th. 1922.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. ..... 19....

20-UNDERTAKER. Commissioner Health. ADDRESS MAY 20 1922

W. W. E. WOODALL

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64756

CERTIFICATE OF DEATH.

3 1 5

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Evans

(a) RESIDENCE. NO. 1127 May ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Lab'r

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Wm. S. Woodall, Md. Penitentiary

Filed MAY 23 1922, 19 ROBERT A. CARTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 21 1922

17 I HEREBY CERTIFY, That I attended deceased from March - 13 - 1922, to May - 21 1922, that I last saw him alive on May - 20 1922, and that death occurred, on the date stated above, at 10.32 A. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.

(duration) yrs. 2 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Sputum Examinations

(Signed) William A. Edwards, M. D.

22, 1924 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER (To the Commissioner of Health, Per. WM. S. WOODALL)

ADDRESS MAY 23 1922

I 6922

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64757

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Walbrook Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Morton

(a) RESIDENCE. No. 3210 Walbrook Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced (write the word): S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (100)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lillie Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant

(Address)

Filed MAY 31 1922 19

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1922

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1922, to May 28, 1922, that I last saw her alive on May 28, 1922, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 months)

6 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R. Cooley, M. D.

, 19 (Address) 753 Dougl St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: [illegible] Funeral Home

ADDRESS MAY 29 19[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D 64758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64758

CERTIFICATE OF DEATH.

161-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 70 WARD)

2-FULL NAME Baby Smith

(a) RESIDENCE No. St. Agnes Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 hrs ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 5-28-22

7 AGE — Years | Months | Days | If LESS than 1 day, 8 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs. Mary Smith

(Address) 4128 Halsted Av

15 MAY 31 1922 — ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-28, 1922, to 5-28, 1922, that I last saw h[illegible] alive on 5-28, 1922, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac failure

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 31 1922

UNDERTAKER: F. B. Kleinert

ADDRESS: 323 Fredk Ave

IMPORTANT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64759

D 64759

CERTIFICATE OF DEATH.

3 Roland Park

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 198 Prospect Ave ST.: 27 WARD)

2-FULL NAME Florence May Starr

(a) RESIDENCE. NO. 198 Prospect Ave ST., WARD 27th

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Clarence R Starr

6 DATE OF BIRTH (month, day, and year): June 21—1878

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
43	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city

PARENTS

10 NAME OF FATHER: John R. Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Annie Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant (Address): Clarence R Starr 198 Prospect Ave

15 Filed 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30th 1922

17 I HEREBY CERTIFY, That I attended deceased from January 11th 1922, to May 30th, 1922, that I last saw h[illegible] alive on May 27—, 1922, and that death occurred, on the date stated above, at 10-15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2- yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Phys. Examination

(Signed) J. Bunnell Lange M. D.

, 19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge DATE OF BURIAL: June 1 19 22

20 UNDERTAKER: A S Marshall ADDRESS: 3540 Ord Rd

WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICAL TREATMENT is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

BROWN

D 64760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64760

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Fremont St., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby Brown

(a) RESIDENCE NO. 111 Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Chas Brown

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary Rothenberg

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Chas Brown
(Address) 111 Fremont Ave

15 Filed ... 19 ... Registrar
1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1922

17

I HEREBY CERTIFY, That I attended deceased from 5/26, 1922 to 5/30, 1922

that I last saw h— alive on 5/26, 1922

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth 4th mo

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W H Bennett Jones, M. D.

5/31, 1922 (Address) 914 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

MAY 31 1922

...UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information ... carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64761

D 64761

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1313 N. Fulton Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Repke

(a) RESIDENCE NO. 1313 N. Fulton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 20 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Germany

PARENTS

10 NAME OF FATHER Henry Repke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Franke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Libby Wette

(Address) 1313 N. Fulton Ave

22 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 30, 1922, that I last saw her alive on May 29, 1922, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis chronica

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. A. H. A. Mayer, M. D.

May 30, 1922 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL June 1 1922

20 UNDERTAKER Wm J. McNeal ADDRESS Norfolk Va

UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state TH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64762

CERTIFICATE OF DEATH.

45 D 64762

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3313 BATEMAN AVE ST., 15 WARD)

2-FULL NAME EDWARD JOSEPH HICKEY

(a) RESIDENCE NO. 3313 BATEMAN AVE ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	MARRIED

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ CLAUDINE VIRGINIA HICKEY

6 DATE OF BIRTH (month, day, and year) OCT 26-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	7	4	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work CLOTHING MANUFACTURER

(b) General nature of industry, business, or establishment in which employed (or employer) CLOTHING

(c) Name of employer HICKEY-MELVIN CO

9 BIRTHPLACE (city or town) GRAND RAPIDS
(State or country) MICHIGAN

PARENTS

10 NAME OF FATHER JAMES HICKEY

11 BIRTHPLACE OF FATHER (city or town) NEW YORK
(State or country)

12 MAIDEN NAME OF MOTHER MARY E. ICHOFF

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant HARRY E. MELVIN
(Address) 16 N GREENE ST

15 Filed ... Registrar
Robert P. Harrison,
Burial Permit Clerk.

MAY 31 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to May 30, 1922, that I last saw him alive on May 30, 1922, and that death occurred, on the date stated above, at 11.15 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

May 31 1922 (Address) 1120 E. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GRAND RAPIDS MICH. DATE OF BURIAL June 1 1922

20 UNDERTAKER Wm J Tuckner & Sons ADDRESS K W Pa

Information should be carefully supplied, so that it may be properly CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64763

CERTIFICATE OF DEATH.

D 64763

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 N Calhoun ST., 16 WARD)

2-FULL NAME Esther Kinnon Scott

(a) RESIDENCE NO. 633 N Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Sloan Scott

6 DATE OF BIRTH (month, day, and year) Aug 8 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse 037

(b) General nature of industry, business, or establishment in which employed (or employer) Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm A Kinnon

11 BIRTHPLACE OF FATHER (city or town) Illinois (State or country) Ill

12 MAIDEN NAME OF MOTHER Catherine Wright

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Sloan Scott (Address) 633 N Calhoun St

Robert F. Harrison, Registrar

MAY 31 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 9th, 1922, to May 30th, 1922, that I last saw her alive on May 30th, 1922, and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

1 hour

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) appendix operation

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? yes Date of April 14-1922

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas, M. D.

19 (Address) 830 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL June 1922

ADDRESS

20 UNDERTAKER W. J. Tucker & Sons

ADDRESS

Information should be carefully supplied in all items, so that it may be in plain terms, so that it may be CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64764

CERTIFICATE OF DEATH.

1560 05

16-005

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: (No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kirchner

(a) RESIDENCE. NO. 3221 Elgt St. City ST.

(Usual place of abode) WARD.

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John + Catherine Kirchner (Parents)

6 DATE OF BIRTH (month, day, and year) Feb. 10, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Kirchner

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAY 31 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

mation should be given in plain terms, so that the CAUSE OF DEATH may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922, to May 30, 1922, that I last saw him alive on May 30, 1922, and that death occurred, on the date stated above, at 12.40 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery

O.V.N.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) T B Gay M. D.

, 19 (Address) John Hop Kins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL May 1 1922

20 UNDERTAKER Tilly and Zeile. ADDRESS 403 S. Wolfe St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bacillary
True dysentery

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64765

D 64765

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Warren Ave ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Speth

(a) RESIDENCE. No. 208 Warren Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooker

(b) General nature of Industry, business, or establishment in which employed (or employer) Barrel Business

(c) Name of employer Geo. Pensel

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. Speth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Tork

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie C. Speth

(Address) 208 Warren Ave

15 Filed May 31 1922 E. P. Harrison, Registrar

MAY 31 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1922, to May 29, 1922, that I last saw him alive on May 29, 1922, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senile Degeneration

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Hammond Jacobs, M. D.

May 30, 1922 (Address) 531 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 1, 1922
20 UNDERTAKER	ADDRESS
Jno. Mus. J. M. Gaehl & Son	801 W. Lexington

mation and CAUSE OF DEATH in plain terms, as under-
CAUSE OF DEATH in plain terms, as under-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64766

CERTIFICATE OF DEATH.

X 38 D 64766

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. Broadway ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Robert. Hartley

(a) RESIDENCE NO. Phillipsburg Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Hartley

6 DATE OF BIRTH (month, day, and year) Nov. 12 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	49	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Operater

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Hartley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Annie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Edith Hartley (Address) Phillipsburg Pa

15 Filed JUN 1 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11 1922 to May 31 1922

that I last saw h alive on May 30, 1922

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (a) Asthma (b) Emphysema Bronchitis (c)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Autopsy.

What test confirmed diagnosis? Clinical Methods.

(Signed) Richard. G Cotlentz, M. D.

. 19 (Address) O.N.D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phillipsburg Pa. DATE OF BURIAL June 1 1922

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

mation should be ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably syphilitic infection.
Treatment for above caused acute poisoning & oedema of lung.

Spec.—1-10-21—M&T—1500 Bks.

D 64767 HEALTH DEPARTMENT—CITY OF BALTIMORE 162 D 64767

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 919 Plum alley ST., 23 WARD)

2-FULL NAME Baby Looney.

(a) RESIDENCE NO. 919 Plum Alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married,~~ Widowed, or Divorced, (write the word)
Male.	Colored	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May. 29 1922

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Lawrence Looney

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Pearl Johnson

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Maryland.

14 Informant Lawrence Looney
(Address) 919 Plum alley

15 Filed JUN 1 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to May 29, 1922, that I last saw him alive on May 29, 1922, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) L. J. Cigney, M. D.

, 19 (Address) Municipality Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn St

DATE OF BURIAL June 1st 1922

20 UNDERTAKER J. W. Brown & Son

ADDRESS 1st or Money

mation should be given in plain terms, so that if may be of certificates.
CAUSE OF DEATH in plain terms, so that if may be of certificates.
TION is very important. See instructions on back of certificates.

Spec.—1c10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 64768

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Washington Blvd WARD 21)

2-FULL NAME Mary E. Green

(a) RESIDENCE NO. 1203 Washington Blvd WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 10 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed~~, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1845

7 AGE: Years 76 Months 10 Days —

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thomas Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Karl C. Kretzschmar

(Address) 1203 Washington Blvd

15 Filed JUN 1 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to May 31, 1922

that I last saw h— alive on May 31, 1922

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 3 yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Maynard Dillon, M. D.

, 19 (Address) 127 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cem — DATE OF BURIAL: June 2 1922

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 217 S Pac

N. B. ... mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 64769 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 64769

REGISTERED NO.

CERTIFICATE OF DEATH.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 N Fremont ST., 16 WARD)

2-FULL NAME Margaret E Clark

(a) RESIDENCE NO. 1307 N Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13 38

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	83	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Md.
(State or country)

PARENTS

10 NAME OF FATHER Pearson Clark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md David

12 MAIDEN NAME OF MOTHER David

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mr Caleb M Clark 246
(Address) 246 Mass ave Washington

15 Filed JUN 1 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 22

I HEREBY CERTIFY, That I attended deceased from May 1-22, 19 ... to May 30/22, 19 ...

that I last saw h... alive on May 29/22

and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* was as follows:

Chronic Cardiac Decompensation

Senility

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. C. Stouck, M. D.

, 19 (Address) 1923 Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

DATE OF BURIAL June 1 1922

20 UNDERTAKER W. M. Rowson

ADDRESS 730 Fremont

mation should be ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64770

CERTIFICATE OF DEATH.

46 D 64770

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2419 W. North ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta G. McCummings

(Residence in Baltimore: No. 2419 W. North ave St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept (Month) 10 (Day), 1853 (Year)

7-AGE, 68 yrs. 8 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home work.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Benj Grafton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Dever

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John McCummings

(Address) 2419 W. Northave

15- JUN 1 - 1922 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 30 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 30 1922, to May 30 1922, that I saw her alive on May 30 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. C. Metzel M. D.

May 31, 1922 (Address) 1903 W. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, June 2, 1922

20-UNDERTAKER W. Maurice Routson

ADDRESS 2238 W. North ave

N. B. CAUSE OF DEATH must be plainly written. Every question must be answered if important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64771

D 64771

CERTIFICATE OF DEATH.

46

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Retreat ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Starr.

(Residence in Baltimore: No. 1527 Retreat St. 82 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept 8th (Month) (Day) 1839 (Year)

7-AGE, 82 yrs. 8 mos. 22 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housework

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Christian Wagner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mc Clark

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Myers

(Address) 1527 Retreat St

15- Filed JUN 1 - 1922, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31st (Month) 31 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14 1922, to May 31st 1922, that I saw h.. alive on May 31st 1922 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Genital Organs

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cause of Senility

(Duration) 2 yrs. 4 mos. ..... ds.

(Signed) H. D. Stevens M. D.

May 31, 1922. (Address) 1601 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, June 2, 1922

20-UNDERTAKER W. M. Routson — ADDRESS 2238 N. Howard

CAUSE OF DEATH must be plainly written. Every question must be answered if possible. Omission of any important item will cause return for correction. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64772

CERTIFICATE OF DEATH.

D 64772

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2532 Fremont ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elisha A Coy

(Residence in Baltimore: No. 2532 Fremont St.; ....yrs., 6 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Married

6-DATE OF BIRTH, Sept 11, 1839 (Month) (Day) (Year)

7-AGE, 82 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Amar Coy

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER — Aramanat

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C Bixler

(Address) 2532 Fremont St

15- ROBERT R. KRAUTER,

Filed JUN 1 - 1922 191... Burial Permit Clerk.

N.B. CAUSE OF DEATH in plain terms is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1922 to May 30 1922, that I saw h[illegible] alive on May 30 1922, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Coronary Obstruction

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Fred B Jewett M. D.

June 1, 1922 (Address) 2576 Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Glenmont Aquilla Co Md

19-PLACE OF BURIAL OR REMOVAL, Greenmount Bural Co

DATE OF BURIAL, June 2., 1922

20-UNDERTAKER H M Rowton

ADDRESS 223 N Howard

Spec.—6-9-19—H. P. Co.—1000 Bks.

Meisel

64773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64773

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1021 N Gilmor ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Musel.

(a) RESIDENCE. No. 1021 N Gilmor ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Musel.

6 DATE OF BIRTH (month, day, and year) 16 Sept 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer) nothing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER William Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Shakespeare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mary Musel

(Address) 1021 N. Gilmor St

15 Filed JUN 1 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5 1922, to May 31, 1922, that I last saw h[illegible] alive on May 31, 1922, and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) Edward Nelson, M. D.

, 19 (Address) 1201 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 2 1922
20 UNDERTAKER Josiah Depue Howard Mark	ADDRESS

CAUSE OF DEATH in plain terms, [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64774

3/

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2913 E. Balto. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frederick G. Herr

(a) RESIDENCE. No. 2913 E. Balto. ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5/1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 569

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Bethlehem Steel works

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Matthew Herr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Catharine Herr

(Address) 2913 E. Balto. st.

15 Filed ..... 19 ..... Registrar

JUN 1 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY that I attended deceased from June 1st 1920 to May 30 22.

that I last saw h[illegible] alive on May 29, 22.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Does not.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] Dooley, M. D.

19 (Address) 2938 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: June 2 1922

20 UNDERTAKER: for J. Herr

ADDRESS: 156 N. Luzerne ave,

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64775

CERTIFICATE OF DEATH.

90 D 64775

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 517 E. 23d (St.:) (Ward) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sue B Mourning

(a) RESIDENCE. No. 517 E. 23d St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Wm Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Elizabeth Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: C. A. Murphy

(Address) 517 E. 23d St

15 Filed JUN 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1922

I HEREBY CERTIFY, That I attended deceased from May 1st, 1922, to May 29th, 1922, that I last saw h[illegible] alive on May 29th, 1922, and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rheumatoid Arthritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? 517 E. 23rd St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Wm Conrad Bode, M. D.

19 (Address) 1900 Maryland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 1 1922

20 UNDERTAKER: H. C. Kindsfield

ADDRESS: 914 Gilmor St.

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. This information is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1576 [illegible] HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 64776

32

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Lee. Qty.

(a) RESIDENCE. No. 552 Lanvale St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Edward Lee father.

6 DATE OF BIRTH (month, day, and year) July 2, 1904.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Edward Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Charlotte Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed JUN 1 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to May 31, 1922, that I last saw him alive on May 31, 1922, at 2 P.M. and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Tbc meningitis

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. S. Burwell, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millenbeck Whf	June 2 1922
UNDERTAKER Lancaster, Co. Va	ADDRESS 142 Ursula St
John H. Toadvine	

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64777 ✓ 31 D 64777

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST.: Municipal Tuberculosis Hospital WARD) 4

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hom See Hou

(a) RESIDENCE. NO. 209 W. Mulberry st. ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] 24 mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Yellow	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work . Laundryman 941

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER -- Hom

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Mon Chang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JUN 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1922, to May 30, 1922, that I last saw him alive on May 30, 1922, and that death occurred, on the date stated above, at 10.55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglacca, M. D.

5-30-22, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Baltimore Cemetery June 3 1922

20 UNDERTAKER — ADDRESS

John O. Mitchell 120 N. Fayette St.

mation should be given in answering this question. CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64778 HEALTH DEPARTMENT—CITY OF BALTIMORE 100 D 64778

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 N. Charles St. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Philip Peterson

(a) RESIDENCE NO. 2119 N. Charles St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Peterson

6 DATE OF BIRTH (month, day, and year) Jany. 6 - 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co? Md.

PARENTS

10 NAME OF FATHER George Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) # John Peterson 1709 Bolton St.

15 Filed JUN 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1922. to May 30. 1922.

that I last saw him alive on May 30. 1922

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) H. H. Pekar M. D.

, 19 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 1—1922

20 UNDERTAKER: John A. Mitchell — ADDRESS: 1201 W. Fayette

mation should be CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

C-64779

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 161-D 01 64779

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1446 William ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Monroe Joseph Downes

(a) RESIDENCE. NO. 1446 William ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/30/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Elmer M. Downes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Carrie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) Elmer M. Downes 1446 William St

15 Filed JUN 1 - 1922 I.E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to May 31, 1922, that I last saw him alive on May 31, 1922, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Premature birth.

about 1 mo.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. E. Stifler, M. D.

5/31, 1922 (Address) 1314 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Patricks Cem. DATE OF BURIAL: June, 1922

20 UNDERTAKER: Margaret G. Flynn ADDRESS 1414 Light St.

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64780

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 64780

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 E. Fanvale ST., 9 WARD)

2-FULL NAME Laurance W. Schmidt

(a) RESIDENCE NO. 1320 E. Fanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23, 1921

7 AGE — Years: — Months: 10 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ---

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Michael A. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr. A. Schmidt
(Address) 1320 E. Fanvale St

15 Filed JUN 1 - 1922 S.E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1922, to May 29, 1922, that I last saw him alive on May 29, 1922, and that death occurred, on the date stated above, at 5-40 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

May 30, 1922 (Address) 120 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: May 1922

20 UNDERTAKER: Lyons - J. Rutter

ADDRESS: 1735 Harford Av.

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64781

CERTIFICATE OF DEATH.

D 64781

REGISTERED NO. 131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin D. Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Vitale

(a) RESIDENCE NO. 146 N. High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 26 1899

7 AGE 23 Years — Months 5 Ds. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 000

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Guiseppe Vitale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rachela Aversa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Gaetano Vitale

(Address) 146 N. High St.

15 Filed JUN 1 - 1922 H. E. Weber

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31 — 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30 — 1922, to May 31, 1922

that I last saw her alive on May 31, 1922

and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Hydronephrosis

Uremia Contributory to Kidney

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 5/30/22

Was there an autopsy? No

What test confirmed diagnosis? Chemical Analysis

(Signed) Newton Evans, M. D.

5/31, 1922 (Address) Franklin D. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL June 2 1922

20 UNDERTAKER George J. Rutt ADDRESS 1735 Harford ave.

mation should be given in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64782

CERTIFICATE OF DEATH.

D 64782

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3019 W North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wallace S. Manrow

(Residence in Baltimore: No. 3019 W North Ave St.; ....yrs., ...mos. ....ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, April 9th, 1866 (Month) (Day) (Year)

7-AGE, 56 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Upholsterer
(b) General nature of industry, business, or establishment in which employed (or employer): O&S

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles T. Manrow

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Henrietta Field

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Sylvester MD

(Address) 701 Maryland Ave

15- JUN 1 - 1922 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31st, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1922, to May 30th 1922, that I saw him alive on May 30th 1922, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial abscess and General Septicaemia secondary to Osteo Myelitis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary): Osteo Myelitis of lower section of Tibia

(Duration) ....yrs. ....mos. 5 ds.

(Signed) Howard Sylvester M. D.

May 31st, 1922. (Address) 701 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, June 3, 1922

20-UNDERTAKER George J. Smith — ADDRESS 1800 W. Fayette

NOTE—CAUSE OF DEATH must be plainly written. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64783

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 204 East Read ST.: 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucia M Roby

(a) RESIDENCE. NO. 204 East Read ST., 11th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry A Roby

6 DATE OF BIRTH (month, day, and year) Nov 12-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penn.

PARENTS

10 NAME OF FATHER Louis Lambert

11 BIRTHPLACE OF FATHER (city or town) Gustavia (State or country) Island of St Bartholomew W.I.

12 MAIDEN NAME OF MOTHER Adriana Martin

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Pa

14 Informant Mrs F M Dingee (Sister)
(Address) 50 S Trenton Ave Atlantic City NJ

15 Filed ..... 19 ..... Registrar

JUN 1 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st, 1922

17 I HEREBY CERTIFY, That I attended deceased from October 29th, 1921, to May 30th, 1922, that I last saw her alive on May 30th, 1922, and that death occurred, on the date stated above, at 4.30, a, m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas, with metastasis to Liver.

(duration) One yrs. XXXXmos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of ---------

Was there an autopsy? No

What test confirmed diagnosis? Vide other side

(Signed) Thomas L. Shearer, M. D.

May 31, 1922 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa — DATE OF BURIAL June 2nd 1922

20 UNDERTAKER Henry N Jenkins & Sons Co — ADDRESS Federal & Lee Sts

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64784

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64784

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. VETERANS' HOSPITAL #56

CITY OF BALTIMORE: (NO. Fort McHenry Md. ST., 24 WARD)

2-FULL NAME Howard J. Foster.

(a) RESIDENCE NO. 2704 Jacob St. Wheeling ST. West Va. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
29		5	8	

186

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass decorator

(b) General nature of industry, business, or establishment in which employed (or employer): Central Glass Wks. Wheeling West Va.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wheeling West Va.

PARENTS

10 NAME OF FATHER Joseph Foster.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wheeling West Va.

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wheeling. West Va.

14 Informant: Hospital Records
(Address) Fort McHenry Md.

15 Filed JUN 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to May 31, 1922.

that I last saw h. im alive on May 31, 1922,

and that death occurred, on the date stated above, at 12' 15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary Tuberculosis far. advanced active.

-- (duration) 2 yrs. 0 mos ... ds.

CONTRIBUTORY (Secondary) --- (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X Ray report.

(Signed) M. V. Foster Surgeon US. P.H.S. M. D.

5/31, 1922 (Address) US. V. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wheeling W. Va. DATE OF BURIAL: June 1 1922

20 UNDERTAKER: Sol Stinson & Bro. ADDRESS 1127 E. Balto St.

Information should be carefully given in plain terms, so that it may be readily understood. CAUSE OF DEATH in plain terms. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64785 — 31 D 64785

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 912 N. Carey ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Enoch Curry

(a) RESIDENCE. NO. 912 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Hewlett Curry

6 DATE OF BIRTH (month, day, and year) Dec 13, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lancaster Co. Va.

PARENTS

10 NAME OF FATHER Joseph F. Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Louisa Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ellicott City Md.

14 Informant (Address) Joseph F. Curry Father 912 N. Carey St

JUN 1 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from February, 1922, to May 31, 1922, that I last saw h.... alive on May 30, 1922, and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab

(Signed) R. L. Norris, M. D.

, 19 (Address) 1729 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star	June 2 1922
20 UNDERTAKER John W Henderson	ADDRESS 1504 E Monument

4 N. B. ... should be carefully ... so that it may be ... mation in plain terms, so that it may be properly ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 D 64786

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lucas

(a) RESIDENCE. No. 1841 N Milton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical work

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER August Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Grindle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Clarence Lucas Kesgung Md.

15 JUN 1 - 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 1922, to 5-31, 1922

that I last saw him alive on 5-31, 1922,

and that death occurred, on the date stated above, at 9:15 m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) carcinoma of pylorus and stomach, cachexia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-3-22

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) R. J. Slyter, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	6/3/1922
20 UNDERTAKER	ADDRESS
E. D. Fanning & Son	1938 E Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64787

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64787

CERTIFICATE OF DEATH.

74

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3105 Foster ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Schader

(Residence in Baltimore: No. 3105 Foster ave St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, Dec 26, 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. 5 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Henry Gessing

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Augusta Shottenberg

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Gessing

(Address) 3105 Foster Ave

15- Filed JUN 1 - 1922, 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31st, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. 1 hour

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

May 31st 1922 (Address) Curtis Bay, Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, June ?, 1922

20-UNDERTAKER Lilly & Gile — ADDRESS 403 S. Gilmor

N.B.—Every item of information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 64738

HEALTH DEPARTMENT—CITY OF BALTIMORE

V-001

74

D 64738

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 911 - So - First St ST. 7th WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredericka Agnes Henker

(Residence in Baltimore: No. 911 — So. First St - St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 6th, 1862
(Month) (Day) (Year)

7-AGE, 60 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, John Stegman

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mary Kahler

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John B. Wenker

(Address) 911 — So. First St

15- JUN 1 - 1922 Filed, 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Sudden

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos B. Horton M. D.
(Coroner)

May 30 1922 (Address) Curtis Bay, Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, June 2, 19..

20-UNDERTAKER Lilly and Zeile ADDRESS 1038 N. Gay St

N.B.—Every item of information must be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64789

D 64789

CERTIFICATE OF DEATH.

REGISTERED NO. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 E Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman M. Canatella

(a) RESIDENCE NO. 302 E. Fayette ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 12 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	10	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer) 500

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Joseph Canatella

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Barbara Troyer

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Joseph Canatella
(Address) 302 E. Fayette St.

15 Filed Robert F. Carrison, 19 Registrar

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to June 1 —, 1922,

that I last saw h— alive on June 1 —, 1922,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria.

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) Philibert Artigiani M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 6/2 1922

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E Baltimore St.

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter) (over)

100 001

D 64790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64790

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baptist Hospital

CITY OF BALTIMORE (NO. 19 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel F. Hart.

(a) RESIDENCE NO. ~~B~~ 1533 Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~77~~	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) 00

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) 00

14 Informant (Address) Baptist Hospital Baltimore, Md.

15 [illegible] 1922 [illegible], 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to May 31, 1922

that I last saw h[illegible] alive on May 31, 1922 1.30 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. Clinical Findings

What test confirmed diagnosis?

(Signed) H. Feldsmith, M. D.

6/3/22 (Address) Baptist Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Leatherdale	June 3 1922
20 UNDERTAKER	ADDRESS
William G. Schaffer	816 Fairmount Ave

N 1

mation should be prepared in plain terms, so that if ma... CAUSE OF DEATH in plain terms, so that it may be prepared... TION is very important. See instructions on back of certificates.

Office Hours:
8 to 9.30 A. M.
6 to 8 P. M.
And by Appointment.

Phone, S

Dr. R. E. L. Campbell
1644 Hanover Street
Baltimore, Md.

D-647

This Certifies
That when I filed our
papers to Commit Wm. Daniel H
to Bay View - I stated the age
72 years should be 62 - owin
to the age given to the city, they
copied same on death certifi
and transcript - Resp
R. E. L. Campbell

June 24/1922

M. L. Lichtenberg M

T OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
PERVISORS OF CITY CHARITIES

McCLEARY.
SUPERINTENDENT
RY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

JUN 5 1922

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

June 3, 1922.

Dr. C. Hampson Jones,
Commissioner of Health,
311 Courtland St.,
City.

My dear Dr. Jones:-

Recently I sent in a certificate of death for one, Daniel J. Hart on which the age was given as 72. I have subsequently found out that this is a mistake and that his correct age was 62. Will you please have same rectified on death certificate?

Thanking you for your favor, I am

Sincerely yours,

H. Hedrich

Physician-in-Chief
Insane Department.

Spec.—6-9-19—H. P. Co.—1000 Bks.

64791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64791

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 720 Portland ST.: 21 WARD)

2-FULL NAME William H Barker

(a) RESIDENCE. NO. 720 Portland ST., 22 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William W Barker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Emma Fagan

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant W. W. Barker
(Address) 720 Portland St.

15 FILED 1922, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb — 1922, to May 31, 1922, that I last saw h— alive on May 30, 1922, and that death occurred, on the date stated above, at 6.40 A m.

The CAUSE OF DEATH* was as follows:

Rheumatism —
(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart
(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gruenhagen, M. D

5/31, 1922 (Address) 847 Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL June 2 1922

20 UNDERTAKER William Cook

ADDRESS 502 E Northam

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

1922

Burial Permit Issued

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 64792

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C 26 1805 D 64792

City of BALTIMORE: (No. Mercy Hospital. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul C. Weging.

(Residence in Baltimore: No. 3707 Gough St. St.; 15 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. October. 5th. 1884. (Month) (Day) (Year)

7-AGE. 37 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer, 040
(b) General nature of industry, business, or establishment in which employed (or employer): American Sugar Refinery.

9-BIRTHPLACE, (State or Country). Germany.

PARENTS

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta Weging. (wife)

(Address) 3707 Gough St.

15- ROBERT N. KRAUTER, Registrar

FILED JUN 3 - 1922 - Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 30th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Combound comminuted fracture of both legs, laceration of both thighs, shock & hemorrhage. Accidentally caught in a sugar machine (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

May 31th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? American Sugar Refinery, May 30, 1922.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cem	6/2/22

20-UNDERTAKER. George W. Farley ADDRESS Fulton & Fayette

state CAUSE OF DEATH in detail. See instructions on back of certificate. This is very important.

Brosius

D 64793

HEALTH DEPARTMENT—CITY OF BALTIMORE

90D 64793

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Calvert Bank Calvert Bank ST.: 17 WARD)

Howard & Saratoga Sts

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Brosius

(Residence in Baltimore: No. Guelford apts Guelford road an- St.: 4 O yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 26 (Day), 1845 (Year)

7-AGE, 77 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Frederick Md

PARENTS.

10-NAME OF FATHER, John Brosius

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER, Mayard Jarboe

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Nannie L Brosius

(Address) Guelford apts

15- JUN 2 - 1922 Filed ....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

N.B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease (Duration) yrs. Dont know mos. ds.

CONTRIBUTORY (Secondary) Dont know (Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner.)

6-7, 1922. (Address) 11 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Johns Cem Frederick	June 2, 1922

20-UNDERTAKER Henry P Jenkins Sons

ADDRESS McCulloh & Orchard

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 D 64794

CERTIFICATE OF DEATH.

Registered No. C.....

64794

1-PLACE OF DEATH
City of BALTIMORE: (No. 351 Fouthill ave St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter A. Hoff

(Residence in Baltimore: No. 351 Fouthill ave St. | yrs. 41 | mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

6-DATE OF BIRTH. May (Month) 26 (Day) 1881 (Year)

7-AGE. 41 yrs. mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Brewer 94
(b) General nature of industry, business, or establishment in which employed (or employer) Yeast works.

9-BIRTHPLACE, (State or Country). Pittsburg Pa.

PARENTS.

10-NAME OF FATHER. Frank Hoff

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Heilbig

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Hoff

(Address) 351 Fouthill ave

15- Filed JUN 2 - 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

N. B.—Every item of information should be given, and if there is any doubt as to how to state CAUSE OF DEATH in plain terms, so that it may be understood, the following paragraph is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 31 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Coroner death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging Suicide

Sudden (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dependancy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D.
(Coroner.)

May 31 1922 (Address) 1002 Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, June 2nd 1922

20-UNDERTAKER, C. W. Dill

ADDRESS 3104 Fredk. Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74 001

D 64795

REGISTERED NO. D 64795

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Maryland General Hospital ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) WARD)

2-FULL NAME Patrick Lane.

(a) RESIDENCE. NO. 232 N. ST., WARD. Sparrows Point, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Margaret Lane.

6 DATE OF BIRTH (month, day, and year) June 1854

7 AGE Years 68 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Flanigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Lane (Wife)
(Address) 232 N. St. Sparrows Point

15 Filed JUN 2 - 1922 19 ROBERT A. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to May 30, 1922, that I last saw h.. alive on May 30, 1922, and that death occurred, on the date stated above, at 7.55 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 232 N. St. Sparrows Pt.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John W. Metcalf, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL June 3rd 1922

ADDRESS 408 S. Wolfe St.

20 UNDERTAKER Lilly & Zeiler

N. B.—WRITE PLAINLY, all items carefully supplied. Attention is called to the fact that it may be property ... mation should be carefully supplied, so that it may be ... of certificates. CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64796

CERTIFICATE OF DEATH.

90 D 64796

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1314 Ensor St ST.: 9 WARD)

2-FULL NAME Frances Reilly

(a) RESIDENCE. No. 1314 Ensor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J. Reilly.

6 DATE OF BIRTH (month, day, and year): Sept 17-1849

7 AGE: Years 72 Months 8 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Park Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Arkansas

14 Informant (Address): R. L. Reilly 1314 Ensor St.

JUN 2 - 1922

ROBERT P. KRAUTH Registrar

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 20th. 1920. to June 1. 1922.

that I last saw her alive on June 1, 1922.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Hemiplegia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Albert Klingenwald, M. D.

6/1/1922 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: June 3 1922

20 UNDERTAKER: H. C. Wedefeld — ADDRESS: 914 Gramont Ave

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—8-24-14—M. & T.—2000 Pks.

D 64797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64797

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame Convent St., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Teresa Ritzhoff

(Residence in Baltimore: No. Augusta St and Ashland Ave St.; 8 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 20 (Day), 1870 (Year)

7-AGE, 51 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Work
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Augustin Ritzhoff

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Gertrude Wareing

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionysia

(Address) Notre Dame Augusta St

15-

Filed....., 191.....

JUN 3 - 1922

Registrar.

CAUSE OF DEATH must be answered in all cases. Be particular and definite. Name disease causing death, not mode of dying. If from violence, state whether accidental, suicidal or homicidal. If from accident, state whether it occurred in mine, factory, railroad, etc. If from typhoid fever, pneumonia, etc., state how long sick. If woman, whether pregnant or recently confined. These items are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 31 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1921, to May 1922, that I saw h.. alive on May 31 1922, and that death occurred, on the date stated above, at 11:5 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

and Myocarditis

..... (Duration) .....yrs. 9 mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) F. D. Kirby M. D.

June 1, 1922. (Address) 116 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md	June 3, 1922

20-UNDERTAKER	ADDRESS
Frank A. Fink	915 E. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64798

64798

160

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kunzler

(Residence in Baltimore: No. 102 N Patterson St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 5 / 31 / 1922
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, 16 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Raymond D Kunzler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth E. D'Harrison

13-BIRTHPLACE OF MOTHER (State or Country), Talbott Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Raymond D Kunzler

(Address) 102 N. Patterson Pk

15-

Filed JUN 2 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 / 31 / 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5/31/1922, to 5/31/1922, that I saw h[illegible] alive on 5/31/1922, and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Stenosis pulmonary Infantile

Atresia completely mother

Pregnancy (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Infantile Stenosis Complete Atresia mother

Pregnancy (Duration) ....yrs....mos....ds.

(Signed) J. Knox Insley M. D.

....., 191... (Address) 2908 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, June 2, 1922

20-UNDERTAKER Henry Lutz

ADDRESS 1203 N Broadway

CAUSE OF DEATH must be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64799

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 E. McElderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis V. Gebhardt

(a) RESIDENCE. NO. 2000 E. McElderry ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? 56 yrs. 6 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Gebhardt

6 DATE OF BIRTH (month, day, and year) Oct. 24-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Gebhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Stumpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) John Gebhardt Sr 2000 McElderry St

15 JUN 2 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to May 29, 1922, that I last saw him alive on May 31, 1922, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Chronic Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 5 1922

20 UNDERTAKER William Eckhaffer ADDRESS 816 E. Monument St

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64800 — 38 D 64800

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bayview Hospital
CITY OF BALTIMORE, (No. ..... ST., 8 WARD)

2-FULL NAME Annie Hedrick

(a) RESIDENCE NO. 2227 Preston Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: John Hedrick

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE: Years 33. Months ..... Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS
10 NAME OF FATHER: Robert Mossbeck
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Bayview Hospital Friends.

15 JUN 2 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1. 1922

17 I HEREBY CERTIFY, That I attended deceased from March 2 1922 to June 1 1922
that I last saw her alive on May 31 1922
and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
General Paralysis (of the Chronic)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lustic Infection
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Clinical & Serological
(Signed) H. Goldsmith M. D.
6/1 1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 1922

20 UNDERTAKER: for Joerdens Bro — ADDRESS: 217 S. Bro

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Spec.—1-10-21 M&T 1500 Bks.

D 64801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64801

CERTIFICATE OF DEATH.

REGISTERED NO. 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3202 O'Donnell ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Agusta Spangler

(a) RESIDENCE NO. 3202 O'Donnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13th 1901

7 AGE: Years 21 | Months 4 | Days 19 | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER John Jacob Spangler

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Alvina V. Roda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Jacob Spangler (Address) 3202 O'Donnell

15 Filed JUN 2 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24th, 1922, to June 12th, 1922, that I last saw her alive on May 31st, 1922, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis.

(duration) yrs. 1 mos 29 ds.

CONTRIBUTORY (Secondary) Myocarditis Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical Symptoms.

(Signed) Chas. E. Hallett M. D.

, 19 (Address) 1315 Mt. Royal Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel Cemetery

DATE OF BURIAL June 5 1922

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

CAUSE OF DEATH to plain instructions on back of certificate. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64802

CERTIFICATE OF DEATH.

X 32 D 64802

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Curtis

(a) RESIDENCE NO. 132 Chesapeake Ave ST., Towson Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 10, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) — 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Marion Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co. Md

12 MAIDEN NAME OF MOTHER Mary Heitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md

14 Informant (Address) John Burns Sons Towson

15 Filed JUN 2 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to May 31, 1922, that I last saw her alive on May 31, 1922, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis and Tb. meningitis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Herman J. Dorf, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest Cem. DATE OF BURIAL June 4 1922

20 UNDERTAKER John Burns Sons ADDRESS Towson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64803

CERTIFICATE OF DEATH.

REGISTERED NO. 174

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 N. Stricker ST.: 16 WARD)

2-FULL NAME Mary Ellen Floyd

(a) RESIDENCE. NO. 926 N. Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year) Dec. 25. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5-	5-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): For private families

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md.

PARENTS

10 NAME OF FATHER Amos Tapscoins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundle Co. Md.

12 MAIDEN NAME OF MOTHER Annie Talbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Md.

14 Informant Sarah D. Prentiss (Address) 524 E. Biddle St.

15 FILED JUN 2 - 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to May 30, 1922, that I last saw her alive on May 30, 1922, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute gastritis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Acute hepatic congest. dur. 4 ds.

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy, M. D.

5-31 1922 (Address) 906 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: June-2 1922

20 UNDERTAKER: Sam'l. W. Chase — ADDRESS: 1400 Madison

CAUSE OF DEATH to be filled in by PHYSICIAN. See instructions on back of certificate. TION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100,001

D 64804

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 S. Decker ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria anna Selin

(a) RESIDENCE. NO. 916 S. Decker Ave ST.. 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos ..... ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1922

7 AGE: Years ..... Months ..... Days 16 If LESS than 1 day, hrs. or min. 5

8 OCCUPATION OF DEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William J. Selin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Unkelmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) William J. Selin 916 S. Decker Ave

15 JUN 2 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to May 31, 1922, that I last saw her alive on May 31, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia Caused by irritation of Napkin on Buttock (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Harvey P. Taylor, M. D.

(Address) 3N S. Highland Ave 5/31, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cem.

DATE OF BURIAL: June 2 1922

ADDRESS: 403 S. Wolfe St.

20 UNDERTAKER: Lilly and Zeile

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64805

REGISTERED NO. D 64805

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

2-FULL NAME Mr. John A. Wettack

(a) RESIDENCE. NO. Nowata Okla ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Maude Wettack (wife)

6 DATE OF BIRTH (month, day, and year) Sept 23, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	7	29.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate Financier.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10 NAME OF FATHER John T. Wettack.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Ella A. Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant JOHNS HOPKINS HOSPITAL. Records
(Address)

15 Filed JUN 2 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922 to June 1, 1922
that I last saw ~~him~~ alive on June 1, 1922
and that death occurred, on the date stated above, at 10½ A. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of intestine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic ileus Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home
Did an operation precede death? Yes Date of 5-29-22
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy
(Signed) W. W. Zinninger, M. D.
(Address) June 1 1922 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Coffeyville Kansas.	June 2/1922
20 UNDERTAKER	ADDRESS
H. E. Hughes 424	N. Broadway

CAUSE OF DEATH. See instructions on other side. TION is very important.

Spec.-1-10-21-M&T-1500 Blks.

(Weil)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64806

D 64806

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2801 Orleans ST., 6 WARD)

2-FULL NAME William H. Weil Jr

(a) RESIDENCE NO. 2801 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mrs Pauline H. Weil

6 DATE OF BIRTH (month, day, and year): 6-1-1893

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
29	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shirt Cutter

(b) General nature of Industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Wm H Weil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Mary A. Cullison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Pauline H. Weil

(Address) 2801 Orleans St

15 , 19 Registrar

Robert F. Hartigan,

Burial Permit Clerk.

JN 8

CAUSE OF DEATH in plain words. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1922

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to June 1, 1922

that I last saw him alive on May 31, 1922

and that death occurred, on the date stated above, at 6.20 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

from history (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Mosheim M. D.

June 1, 1922 (Address) 3150 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland — DATE OF BURIAL: 6/3 1922

20 UNDERTAKER: William Cook — ADDRESS: 802 Wash

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64807.

CERTIFICATE OF DEATH.

117 D 64807

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Buttstofsky

(a) RESIDENCE. NO. 2417 Fait Ave. ST. WARD. Canton, Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work Steadne 94

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Buttstofsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 2 1922 J E Welsh Registrar

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of CERTIFICATE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1922, to June 2 1922, that I last saw h[illegible] alive on June 2 1922, and that death occurred, on the date stated above, at 4:10 A.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute appendicitis ruptured

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 1-1922

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Warfield M Fror, M. D.

6/2, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL June 3 1922

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64808

CERTIFICATE OF DEATH.

127-002

D 64808

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S Regester ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Karpinski

(a) RESIDENCE. NO. 710 S Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 24 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Januszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Karpinski
(Address) 710 S Regester

15 Filed JUN 2—1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 1, 1922,
that I last saw h[illegible] alive on May 31, 1922,
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:

carcinoma of liver

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Valentine, M. D.
June 2, 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	June 3 1922
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 64809

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 753 W. Hamburg ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Weiner

(a) RESIDENCE NO. 753 W Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Weiner

6 DATE OF BIRTH (month, day, and year) Sept 22 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) Her Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Charles Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Boseke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew Weiner (Address) 753 W Hamburg st

15 Filed JUN 2 - 1922 19 F. E. Wehn Registrar

CAUSE OF DEATH IN PUERPERAL CONDITION. See instructions on back of certificate. This information is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from April 30 1922, to May 30 1922, that I last saw her alive on May 30 1922, and that death occurred, on the date stated above, at 11.5 P m.

The CAUSE OF DEATH* was as follows: Epithilioma of Cervix Uteri

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious inforation wound

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 22nd

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank N. Hillis M. D.

, 19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL June 3 1922

20 UNDERTAKER John F Denny — ADDRESS 715 Light st

Spec.—8-24-14—M. & T.—2000 Bks.

D 64810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64810

CERTIFICATE OF DEATH.

57

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S. Chester ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michel Bonarski

(Residence in Baltimore: No. 316 S. Chester st St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Michal Bonarski

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bonarski

(Address) 316 S. Chester St.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

2 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1917, to May 31 1922, that I saw him alive on ....., 1922, and that death occurred, on the date stated above, at 5-20 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac

..... (Duration) 5 yrs. 3 mos. ds.

(Signed) A. J. Fridonis M. D.

6/1, 1922. (Address) 918 E. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, June 3, 1922.

20-UNDERTAKER Jacob Zick Co. ADDRESS Nat. Ave.

important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64811

D 64811

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Mrs Lutie Steele

(a) RESIDENCE NO. Howard Co ST., Md WARD Ellicott City Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. H. Steele

6 DATE OF BIRTH (month, day, and year) Sept 15, 1886

7 AGE Years 35 Months 8 Days 16 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Greer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Mercy Hospital Records (Address)

15 Filed ..... 19 ..... Registrar Robert F. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1922 to June 1, 1922.

that I last saw her alive on June 1, 1922

and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows: Threatened Miscarriage

(complete)

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Tetanus.

(duration) ..... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home O.K. A. T. Riley

Did an operation precede death? No Date of

Was there an autopsy? Yes Coroner

What test confirmed diagnosis? Symptoms

(Signed) John W. Lewis, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co St. Johns Lutheran Cem DATE OF BURIAL June 4 1922

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificate. TION is very important.

2-1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

15-62-52

D 64812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64812

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry R. Hilgert

(a) RESIDENCE. No. 101 Beaumont Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. 4 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) Jan 21 - 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	4	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Benjamin Hilgert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Kroeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed Robert P. Harrison, Registrar

12-1922 Burial Permit Issued

CAUSE OF DEATH. See instructions on back OF CERTIFICATE. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 31 1922

17 I HEREBY CERTIFY, That I attended deceased from MAY 29, 1922, to MAY 31, 1922, that I last saw him alive on MAY 31, 1922, and that death occurred, on the date stated above, at 8:00 A m.

The CAUSE OF DEATH* was as follows:

DIABETES MELLITUS

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) ACIDOSIS

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Jonsey, M. D.

. 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 6/3 1922

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: N. Calvert

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64813

CERTIFICATE OF DEATH.

74-001 D 64813

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4th Ave. near 9th St Fairfield (WARD) 25

2-FULL NAME Catherine Spencer

(a) RESIDENCE NO. 4th Ave. near 9th St Fairfield WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Joseph Spencer

6 DATE OF BIRTH (month, day, and year) March 17, 857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER James Marion Ireland

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Annie Lemm Ireland

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Rose Wisecher

(Address) 4th Ave near 9th St Fairfield

15 Filed ..... 19 ..... Registrar

2-1922

CAUSE OF DEATH must be plainly written. See instructions on back of Certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1922, to June 1, 1922, that I last saw her alive on May 31, 1922, and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

caused by gangrene of left foot. Duration 10 weeks

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) mitral insufficiency cerebral Hemorrhage (duration) yrs. 6 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo Edwards, M. D.

6/1, 1922 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 6/3 1922

20 UNDERTAKER Jos. L. Vahey & Sons

ADDRESS 1318 Light St.

Spec.—5-9-19—H. P. Co.—1000 Bks.

D 64814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64814

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Somerset apt. ST. 12 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mary A. Hubner.

(a) RESIDENCE. NO. Somerset Rd & Mt. Pkwy St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~ Widowed, ~~or Divorced~~ (write the word): Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~: John Hubner

6 DATE OF BIRTH (month, day, and year) 1842-11-25

7 AGE: Years 79 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House hld wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry Harken

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary A Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): W. R. Hubner, Somerset apt.

15 Filed Jan 2 1922 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 16, to June 1st 1922, that I last saw her alive on June 1st 1922, and that death occurred, on the date stated above, at 8-30 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency,

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? symptoms & history

(Signed) J. A. Bullard, M. D.

June 2nd 1922 (Address) 400 W. Biddle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL 6-3 1922

20 UNDERTAKER: Henry W. Justice & Bro — ADDRESS Mulberry & Orchard

CAUSE OF DEATH. See instructions on back. TION is very important.

D 64815

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64815

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1008 Riverside Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wm Kelly

(a) RESIDENCE No. 1008 Riverside Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Kelly

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 130

(b) General nature of industry, business, or establishment in which employed (or employer) Rail Road

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Doarn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward Kelly
(Address) 1621 N Bathurst St

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1922, to May 30, 1922, that I last saw him alive on May 30, 1922, and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) G. D. Buxton, M. D.

6/2, 1922 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	June 3 1922
20 UNDERTAKER Maynard L. Sloan	ADDRESS 1421 Light St

CAUSE OF DEATH. See instructions on back. IMPORTANT. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64816 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64816

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4005 Liberty Hgts ST., 15 WARD)

2-FULL NAME George Mildred Roberts

(a) RESIDENCE No. 4005 Liberty Hgts ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Kemper Roberts

6 DATE OF BIRTH (month, day, and year): Sept 10 1854

7 AGE: Years 68 Months 8 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oyster Packer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: J. J. C.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Sarah Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Louisa K. Roberts

(Address) 4005 Liberty Hgts ave

15 Filed ..... 19 ..... Registrar .....

Robert P. Harrison,
Burial Permit Clerk.

N2 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to May 31, 1922, that I last saw him alive on May 31, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Symptoms ended)

(duration) yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Hypertrophy of heart

(duration) yrs. ..... mos. 10 minutes ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Jerrmacon G. Lee M.D., M. D.

, 19 (Address) 90 W. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 3 1922

UNDERTAKER: H. Friedman Sons

ADDRESS: N Y Pa

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1060 Bks.

D 64817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64817

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST.: 4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. V. Brown.

(a) RESIDENCE. NO. Orkington Rd. ST.: Catonsville Md. WARD. Catonsville Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of Marcus H. Brown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Talbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital Records.
(Address)

15 Filed [illegible], 19[illegible] Registrar

[illegible]3—1922 [illegible] Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to June 1, 1922, that I last saw her alive on June 1st, 1922, and that death occurred, on the date stated above, at 4:40 P.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Omentum
as Necessary

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of June 1st 1922

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) E. E. Broadrup. M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and ~~Nature~~ of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: June 3/22

20 UNDERTAKER: Chas. E. Franck ADDRESS: 502 Madison Ave.

TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64818 D 64818

CERTIFICATE OF DEATH. X 117

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Stuller

(a) RESIDENCE NO. Westminster Md ST., WARD Westminster Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 mos 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. J. Miller

6 DATE OF BIRTH (month, day, and year) Oct. 10 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Shanabrough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Angelina Stuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John J. Miller (Address) Union Mills Md.

15 Filed ....., 19 ..... Registrar

3-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1922

17 I HEREBY CERTIFY, that I attended deceased from May 22, 1922, to June 2, 1922, that I last saw h[illegible] alive on June 2, 1922, and that death occurred, on the date stated above, at 9:15 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Appendicial Abcess. (duration) 3 mos 3 ds.

18 Where was disease contracted if not at place of death? Westmt Md.

Did an operation precede death? Yes. Date of May 20.

Was there an autopsy? No.

What test confirmed diagnosis? Typical typical typ.

(Signed) Harold C. Gillsbury M. D.

19 (Address) 415 Cedarcroft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co. Md Union Mills Cemetery. DATE OF BURIAL June 4 1922

20 UNDERTAKER George F. Rutt ADDRESS 1135 Harford Ave

CAUSE OF DEATH. See instructions on back of Certificate. ATION is very important.

Robert F. Harrison, Registrar of Vital Statistics.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64819

D 64819

38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH U.S.V.HOSP.#56,

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME PETER REILLY

(a) RESIDENCE NO. 542 St.Peter St. New Orleans, La. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	49	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant HOSPITAL RECORDS, (Address) Fort McHenry,Md

15 Filed ....., 19 ..... Registrar

CAUSE OF DEATH. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to May 31, 1922, that I last saw him alive on May 31, 1922, and that death occurred, on the date stated above, at 11:20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombi, Emboli and Infarct

Fracture right hip (lues) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Nos Date of --May 22/22

Was there an autopsy? Yes

What test confirmed diagnosis? Clinic report.

(Signed) [illegible] M. D.

5/31/22 (Address) SURGEON,U.S.P.H.S.U.S.A. USVHosp.#56,Ft.McHenry,Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery DATE OF BURIAL June 2, 22

20 UNDERTAKER [illegible] ADDRESS 1127 E Baltimore St

Robert F [illegible]
Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64820

REGISTERED NO. 164

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO.) 1625 N. Monroe St. (ST.) 15 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine J. Davidson.

(a) RESIDENCE. NO. 1625 N. Monroe ST. 15 WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse L Davidson

6 DATE OF BIRTH (month, day, and year)
7 AGE — Years: 83 | Months: 1 | Days: 11 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS
10 NAME OF FATHER: Franklin
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Porter
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Jos L & D Bowers 1625 N Monroe

15 Filed ... 19... Robt. P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 1921, to June 1 1922.
that I last saw h— alive on June 1-22
and that death occurred, on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

(a) Terminal Acute Pleurisy
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. C. Houck, M. D.
, 19 (Address) 1929 W Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Bur Gd Co Md
DATE OF BURIAL: June 4 1922
20 UNDERTAKER: W. M. Roulson
ADDRESS: 22 S Fr Ave

CAUSE OF DEATH MUST BE FILLED IN BY PHYSICIAN IF POSSIBLE. See instructions on back. IT IS very important.

JUN 3 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

155771; D 64821;

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64821

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (St.:) 21 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Hazelton.

(a) RESIDENCE. No. 1013 Warner St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced (HUSBAND of / ~~WIFE of~~) Frennie Hazelton (MOTHER)

6 DATE OF BIRTH (month, day, and year) June 5, 1921.

7 AGE — Years: — Months: 11 Days: 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Oscar Hines.

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ?

12 MAIDEN NAME OF MOTHER Frennie Hazelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed ..., 19... Registrar

Robert F. Harrison

3 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to June 1, 1922, that I last saw him alive on June 1, 1922, and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6+ mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray & Lumbar puncture.

(Signed) Horace G. Stewart, M. D.

6/2, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn St — DATE OF BURIAL: June 3 1922

20 UNDERTAKER: J. H. Brown & Son — ADDRESS: 1080 W Fayette

CAUSE OF DEATH TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

D 64822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 64822

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 E. Preston St. ST., 10 WARD)

2-FULL NAME Annie. Theresa. Eckert.

(a) RESIDENCE NO. 1009 E. Preston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. --- mos. --- ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry. A. Eckert

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Rose Riley 1009 E. Preston St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-2-1922

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922, to June 1, 1922, that I last saw h alive on June 1, 1922, and that death occurred, on the date stated above, at 1:20 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteri-Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

6-2-1922 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount cemetery

DATE OF BURIAL June-5-1922

20 UNDERTAKER Henry Hosch Son

ADDRESS 1301 E Eager St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

NS—1922 Robert F. Harrison, Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64823

CERTIFICATE OF DEATH.

61-001

D 64823

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Calhoun St. ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME June Naylor

(Residence in Baltimore: No. 112 N. Calhoun St. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem	W	Baby

6-DATE OF BIRTH. June (Month) 2 (Day), 1922 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 1 hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Naylor

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Matilda Goodman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Thumberger R.N.

(Address) 112 N. Calhoun St.

15-

Filed....., 19..... Registrar.

3 - 1922 Burial Permit Clerk.

important. See instructions on

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1922, to June 2 1922, that I saw h[illegible] alive on June 2 1922, and that death occurred, on the date stated above, at 4 45 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) B. P. Innes M. D.

June 2 1922 (Address) 1013 W. Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Vincents	June 5, 1922
20-UNDERTAKER	ADDRESS
Kendall & Heppenstall	37 St Paul St

Spec.—6-0-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64824

D 64824

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Nelson

(a) RESIDENCE. No. 541 St.Mary's St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~the WIFE of~~ Josephine Nelson Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coachman 023

(b) General nature of industry, business, or establishment in which employed (or employer) Undertaker Est.

(c) Name of employer Samuel T. Hemsley

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Maryland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed Robert F. Harrison, Registrar

JUN 3-1922

Burial Permit [illegible]

CAUSE OF DEATH. See instructions on back of ... TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to May 31, 1922, that I last saw him alive on May 30, 1922, and that death occurred, on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/31/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL June 3 1922

20 UNDERTAKER Samuel T. Hemsley ADDRESS Mt. Auburn

D 64825 HEALTH DEPARTMENT—CITY OF BALTIMORE 64825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1309 Upton St., St., 17 Ward)

2-FULL NAME (William) Lewis Crutchfield

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1309 Upton St., St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): married

6-DATE OF BIRTH: about (Month) (Day) 1854 (Year)

7-AGE: 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): all

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Crutchfield

(Address) 1309 Upton St.,

15- June 23 1922 Robert F. Harrison, Registrar.

Burial Permit mark.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) yrs. 4 mos. ds.

(Signed) J. C. H. Hemmeter M. D. (Coroner.)

June 21 1922 (Address) 2512 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, June 24 1922

20-UNDERTAKER, Daniel Eastern ADDRESS 716 Park

It is very important. See instructions.

pec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64826

CERTIFICATE OF DEATH.

159-002

D 64826

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Laws

(a) RESIDENCE. No. 1201 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Laws

11 BIRTHPLACE OF FATHER (city or town) (State or country) Athens Greece

12 MAIDEN NAME OF MOTHER Genivieve Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Mrs. Genivieve Laws

(Address) 1201 N. Caroline St.

15 Filed 19 Robt. F. Harrison, Registrar

3-1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1922, to June 2, 1922, that I last saw him alive on June 2, 1922, and that death occurred, on the date stated above, at 1 30 A.M.

The CAUSE OF DEATH* was as follows: Patent foramen ovale

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Stanley W. Matthews, M. D.

, 19 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 3 19

20 UNDERTAKER Harry H. Witzke

ADDRESS 1581 W. Lombard

TION is very important. See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64827

D 64827

CERTIFICATE OF DEATH.

REGISTERED NO. C 44

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3804 Montgomery Ave ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank P Kinsley

(Residence in Baltimore: No. 3804 Montgomery Ave St.; 57 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 28 (Day), 1865 (Year)

7-AGE, 70 yrs. 11 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Supply Dept
(b) General nature of industry, business, or establishment in which employed (or employer): New Amsterdam Casualty Co

9-BIRTHPLACE, (State or Country), Akron Ohio

PARENTS.

10-NAME OF FATHER, Charles Kinsley

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, Harriett Raymond

13-BIRTHPLACE OF MOTHER (State or Country), Hengolen Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Esther Dare Kinsley

(Address) 3804 Montgomery Ave

15- Filed ....., 191.... Robert F. Harrison Registrar.

3-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14 1922, to June 14 1922, that I saw h~~im~~ alive on May 31 1922, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Gall Bladder Infection

Probably Malignant

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) A. C. Bunch M. D.

June 14, 1922 (Address) 4219 Liberty Heights

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

In the State ....yrs. ....mos. ....ds.

At place of death ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, June 3, 1922

20-UNDERTAKER Harry A Inwood

ADDRESS 4204 Ridgewood Ave

important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64828

D 64828

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Foster Ave ST., 36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka C. Thiel

(a) RESIDENCE No. 3710 Foster Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Late Julius L. Thiel

6 DATE OF BIRTH (month, day, and year) Nov 26 - 57

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs L. Keller (Address) 3710 Foster Av

15 Filed ..... 19 ..... Registrar Robert F. Harrison,

N 3 - 1922 Burial Permit Issued

CAUSE OF DEATH MUST BE GIVEN IN PLAIN ENGLISH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to May 19, 1922, that I last saw h[er] alive on May 19, 1922, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma — —

Mitral Insufficiency. —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Feb. 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. McClanahan, M. D.

June 2 1922 (Address) 3508 Round Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL June 3 1922

20 UNDERTAKER Philip Herwig ADDRESS 2016 Oden

D 64829 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D 64829

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1727 Caswell St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ernest P. Brandt

(Residence in Baltimore: No. 1727 Caswell St.; yrs., 53 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH, Dec (Month) 14 (Day) 1848 (Year)

7-AGE, 73 yrs. 5 mos. 19 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cementer
(b) General nature of industry, business, or establishment in which employed (or employer) (Retired) 83

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Brandt (Wife)

(Address) 1727 Caswell St

15- Robert P. Harrison,

Filed JUN 3 1922 Registrar.

Burial Permit Issued.

is very important. See Instructions.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation
Hanging by neck
(Suicide)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Falter M. D.
(Coroner.)

June 2 1922 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cem. | DATE OF BURIAL, 6/5 1922

20-UNDERTAKER, Philip J. Herring | ADDRESS 2016 Aliceanna St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64830

CERTIFICATE OF DEATH.

D 64830

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 408 N High (St.) 5 (Ward) 31

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Cain

(Residence in Baltimore: No. 408 N High St.; ...yrs. Life mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word.) Married

6-DATE OF BIRTH, July (Month) 22 (Day), 1894 (Year)

7-AGE, 27 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Adam Schramm

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary Peterson

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm D Carse

(Address) Carse & Goudelock

15-

Filed....., 191....

Robert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1922 (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 22 1917, to June 2 1922, that I saw h[illegible] alive on June 1 1922, and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ...mos. ...ds.

(Signed) Wm D Carse M. D.

June 2, 1922 (Address) Carse & Goudelock

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Paul's Cemetery

DATE OF BURIAL, June 5., 1922

20-UNDERTAKER H. Sander & Sons

ADDRESS 1710 Fleet St.

Important. See instructions on [illegible]

3 - 1922 Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64831

CERTIFICATE OF DEATH.

90 D 64831

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Montford Ave ST., 6 WARD)

2-FULL NAME Margaret Riefner

(a) RESIDENCE NO. 5 N. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Riefner

6 DATE OF BIRTH (month, day, and year) Jan 4, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Luft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant William H. Riefner (Address) 5 N. Montford Ave

15 Robert [illegible], Registrar

Filed ....., 19.... 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 2, 1922, that I last saw h.e alive on May 30, 1922, and that death occurred, on the date stated above, at 8 9, m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Preston M. D.

June 3, 1922 (Address) Dev Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 5 1922
20 UNDERTAKER	ADDRESS
A. Sander & Sons	170 Flat St

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64832

CERTIFICATE OF DEATH.

3/ D 64832

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) 9 (Ward)

2-FULL NAME George B. Markert

(a) RESIDENCE. No. 1904 Kennedy ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: George Markert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Magdalena Hennemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hospital Records M.T.H.

15 Filed 19 [illegible] Harrison, Registrar

3-1922

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 15 . 1915. to June 1 . 1922.

that I last saw him alive on June 1 . 1922.

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Sedaghuell, M. D.

6-2-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cath. Cem.	June 2 1922
20 UNDERTAKER	ADDRESS
Robt. Johnston	N. Paca

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64833 D 64833

CERTIFICATE OF DEATH.

REGISTERED NO. 161-001

1-PLACE OF DEATH 1509 Madison ave

CITY OF BALTIMORE: (No. 1509 Madison ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Muried Sauers Hall

(a) RESIDENCE NO. 1509 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 30 1922

7 AGE: Years — Months 1 Days 32 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Bradley E Hall

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine J Ricks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mother Mrs Catherine J Ricks (Address) 1509 Madison ave

15 Filed June 3 1922 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1 1922, to June 2 1922, that I last saw her alive on June 2 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

Autopsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C C Maddux M. D.

June 2, 1922 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL 19

20 UNDERTAKER (Name) (Address) ADDRESS JUN 3 1922

CAUSE OF DEATH. See instructions on back of Certificate. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Was a Premature Birth

Malnutrition

Spec.—1-10-21—M&T—1500 Bks.

D 64834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64834

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W.D. Chichester

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1922

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to May 31, 1922,

that I last saw him alive on May 30, 1922,

and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

5/31/22 Address: Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUN 3 1922

CAUSE OF DEATH. See instructions on back. TION is very important.

3-1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64835

CERTIFICATE OF DEATH.

15-90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1527 N. Mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Henry Burr,

(a) RESIDENCE. No. 1527 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer Unknown Baltimore, Md

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm. B. Burr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County, Md.

12 MAIDEN NAME OF MOTHER Laura Rowe Shent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Laura D. Rowe Burr,
(Address) 1527 N. Mount St.

15 Filed , 19 Robert F. Karrison, Registrar

N 3 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1922, to May 30, 1922, that I last saw h[illegible] alive on May 30, 1922, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Exam. + symptoms

(Signed) John D. Quinn, M. D.

(Address) 1501 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	June 4 1922
20 UNDERTAKER James A. Dennis & Grentham	ADDRESS 1313

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64836

CERTIFICATE OF DEATH.

118-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Jacob Smoose

(a) RESIDENCE NO. Kingsville Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? 50 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Muller

6 DATE OF BIRTH (month, day, and year) July 30, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant C. E. Luther Fork Md (Address)

15 Filed ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

4 - 1922

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1922

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1922, to June 2, 1922, that I last saw him alive on June 2, 1922, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 2, '22

Was there an autopsy? No.

What test confirmed diagnosis? P.S. & S.

(Signed) Harold C. Pillsbury, M. D.

, 19 (Address) 405 Cedarcroft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kingsville Md DATE OF BURIAL June 4 1922

20 UNDERTAKER E. Leroy Stiffler ADDRESS 125E North Ave

64837
D 64837

HEALTH DEPARTMENT—CITY OF BALTIMORE

64837
D 64837

CERTIFICATE OF DEATH.

1531

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1614 Presstman St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John L. Alton .....

(Residence in Baltimore: No. 1614 Presstman St.; yrs. 18 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: March 19 (Month) ~~[illegible]~~ (Day) 1905 (Year)

7-AGE: 17 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ~~[illegible]~~

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: John W. Alton

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Annie Gurley

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. W. Alton

(Address) 1614 Presstman

15- June 3 1922 — ROBERT R. KNAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

June 3 1922 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, June 3 1922

20-UNDERTAKER, Edward Pugsley — ADDRESS, 1463 Carey St

is very important. See instructions

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64838

CERTIFICATE OF DEATH.

101-001 D 64838

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2905 Walbrook Av ST., 15 WARD)

2-FULL NAME James O. Lyness

(a) RESIDENCE NO. 2905 Walbrook Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred over 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Cullen Lyness

6 DATE OF BIRTH (month, day, and year) Sept. 21/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter in Saloon

(b) General nature of industry, business, or establishment in which employed (or employer) Produce 166

(c) Name of employer J. B. Nichol & Son Troy N. Y.

9 BIRTHPLACE (city or town) Troy N. Y.
(State or country)

PARENTS

10 NAME OF FATHER James Lyness

11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Blackstock

13 BIRTHPLACE OF MOTHER (city or town) Balto Co Md.
(State or country)

14 Informant Mrs Emma Lyness
(Address) 2905 Walbrook Av

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26 1922 to June 1st 1922.

that I last saw him alive on June 1st 1922,

and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Failing Heart 16 hrs.
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual.

(Signed) E. H. Smith, M. D.

6/2, 1922 (Address) 1605 N North av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6-5-1922

20 UNDERTAKER Henry C. Branning Son

ADDRESS 517 N. Schroeder St

CAUSE OF DEATH. See instructions on back. TION is very important.

Annello

64839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64839

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hosp St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John J. Annella

(Residence in Baltimore: No. 1200 E Monument St.; yrs.....mos.....ds.)

Since Birth

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~ or Divorced, (Write the word.) Single

6-DATE OF BIRTH. July (Month) 30 (Day) 1921 (Year)

7-AGE. ....yrs. 10 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Saml T. Annella

11-BIRTHPLACE OF FATHER, (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Lina Lagrande

13-BIRTHPLACE OF MOTHER, (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saml T. Annella

(Address) 1200 E Monument

15- JUN 4 - 1922 192.....

ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns

.....(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) over

.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Patton M. D.
(Coroner.)

June 3 1922 (Address) 506 E Fort Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	June 6th 1922
20-UNDERTAKER.	ADDRESS
George Schilling & Sons	1126 E Monument St

is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64840

CERTIFICATE OF DEATH.

31

D 64840

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3911 Mount Pleasant Ave WARD 16)

2-FULL NAME Mary Kreuzig

(a) RESIDENCE NO. 3911 Mount Pleasant WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Kreuzig

6 DATE OF BIRTH (month, day, and year): May 20, 1886

7 AGE: Years 36; Months; Days 15; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

03

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Karl Poprotzki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Meisinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm Kreuzig (Address) 3911 Mt Pleasant

15 Filed JUN 4 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1921, to March 21, 1922 that I last saw h[illegible] alive on March 21, 1922 and that death occurred, on the date stated above, at 3 - a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pulmonary Tuberculosis Laryngeal

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas. McC. Mavadon M. D.

June 2, 1922 (Address) 3508 Gant Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: June 1922

20 UNDERTAKER: John Ulrich — ADDRESS: 2008 Eutaw

CAUSES ... TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64841

D 64841

109,002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2328 Mellinian St., 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orvin Eliason

(a) RESIDENCE NO. 2328 Mellinian St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 25 - 1914

7 AGE: Years 8 Months 4 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Elmer Eliason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Elizabeth Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Elizabeth Nelson

(Address) 2328 Mellinian

15 JUN 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 3, 1922, that I last saw him alive on June 3, 1922, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis due to Rheumatic Fever Complications

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) J. Murphy, M. D.

June 3, 1922 (Address) 800 N. Patt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: June 5 1922

20 UNDERTAKER: John Dellrich

ADDRESS 2018 Eden

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64842

CERTIFICATE OF DEATH.

32

D 64842

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Pine St. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Howard

(Residence in Baltimore: No. 205 N Pine St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, January (Month) 2nd (Day), 1922 (Year)

7-AGE, ... yrs. 4 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Leroy Howard

11-BIRTHPLACE OF FATHER (State or Country), V.A

12-MAIDEN NAME OF MOTHER Ema Smith

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ema Howard

(Address) 205 N Pine

15-

Filed ....., 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit

JUN 4 - 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2nd (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 19 1922 to June 1 1922, that I saw him alive on June 1 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

T.B. Meningitis

Contributory Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insuff

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Leyer M. D.

June 4, 1922 (Address) 541 N. Milton Ave. Hospital Baby Clinic

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Orf Altm

DATE OF BURIAL, June 4, 1922

20-UNDERTAKER P L Parham

ADDRESS 220 N Walnut

Important. See instructions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gilbert ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64843

CERTIFICATE OF DEATH.

D 64843

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 614 Wyanoke Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George T. Gilbert

(a) RESIDENCE. NO. 614 Wyanoke Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Fisher Gilbert

6 DATE OF BIRTH (month, day, and year) Nov 5 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	67	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 088

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Wm B. Gilbert

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Rinehart

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Padgett (Address) 614 Wyanoke Ave

15 Filed JUN 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to June 2, 1922, that I last saw him alive on June 2, 1922, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Uraemic conditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Emma S. Magee, M. D.

6/2, 1922 Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	June 5 1922

20 UNDERTAKER	ADDRESS
Wm C. Black	927 N. Broadway

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64844

D 64844

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Valley View Ave ST., Gardenville WARD)

2-FULL NAME Emma M Booz

(a) RESIDENCE No. 309 Valley View Ave ST., Gardenville WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William M. Booz

6 DATE OF BIRTH (month, day, and year) Sept 25-1857

7 AGE — Years: 70 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip Rigby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Grace D. Booz
(Address) 309 Valley View Ave

15 JUN 4 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to June 1, 1922, that I last saw her alive on June 1, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular
Coma

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Cut Hopelessness

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Gustave A Fritz, M. D.

6/2 1922 (Address) Severed.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 6/5 1922

20 UNDERTAKER William Cook

ADDRESS 502 W Lex

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-08 64845

CERTIFICATE OF DEATH.

D 64845

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 North Kenwood ST., 6 WARD)

2-FULL NAME John W. Laird

(a) RESIDENCE NO. 409 North Kenwood ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Nellie A Laird

6 DATE OF BIRTH (month, day, and year) Feb 10 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Self-

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oriole Maryland

PARENTS

10 NAME OF FATHER John W. Laird

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oriole Maryland

12 MAIDEN NAME OF MOTHER Annie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oriole Maryland

14 Informant Warren W. Laird

(Address) 409 N. Kenwood

15 JUN 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CAUSE OF DEATH. See instructions on reverse side. IMPORTANT. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 2 - 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 2, 1922, that I last saw him alive on June 2, 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

30 hrs

(duration) yrs.

CONTRIBUTORY (Secondary) Asthma (duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Ralph L Stoyt, M. D.

, 19 (Address) 26 E Preston St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 6/5 19 22

20 UNDERTAKER McKeown Cook

ADDRESS 502 E Nath St

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64846 — 74-001 — D 64846

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1229 Hanbut ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Peterson

(a) RESIDENCE NO. 1229 Hanbut ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of – Jno Peterson

6 DATE OF BIRTH (month, day, and year) Dec 6 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10 NAME OF FATHER – Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant – Jno Peterson (Address) 1229 Hanbut St

15 Filed JUN 4 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10 22, 19..., to June 3 22, 19..., that I last saw h[e] alive on June 3 22, 19..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) – Senile Debility

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Mueller M. D.

June 3 1922 (Address) 1014 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 6 1922

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

CAUSE OF DEATH is very important. See instructions on

Spear-8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

347 D 64847

CERTIFICATE OF DEATH.

90 D 64847

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1770 E North Av ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Marguerite Seabrease

(Residence in Baltimore: No. 1770 E. North Av — St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb. 24 (Month) (Day), 1896 (Year)

7-AGE, 26 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm H Truelove

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Katherine C Simcoe

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. H. Truelove

(Address) 1770 E. North Ave.

15- Filed JUN 4 - 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1922, to June 2 1922, that I saw her alive on June 2 1922, and that death occurred, on the date stated above, at 12-40 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (Duration) ....yrs.....mos. 1 ds.

(Signed) E. Gill Hall M. D.

June 3., 1922 (Address) 1617 E North av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemtery. DATE OF BURIAL, June 5, 1922

20-UNDERTAKER George J. Ruth ADDRESS 1735 Hanford av.

Important—See that every question is answered.

pec.—6-9-19—H. P. Co.—1000 Bks.

13 6 64848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 64848

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Charles Muhlbach

(a) RESIDENCE. NO. 1019 E. North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 20th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Arthur Charles Muhlbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Klopfer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUN 4 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1922, to June 3rd, 1922, that I last saw h[illegible] alive on June 3rd, 1922, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Septicaemia - (Focus undetermined) -

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? Blood culture —

(Signed) Horace G. Stewart, M. D.

6/4, 15th (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: June 5th 1922

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Bks.

D 64849

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 64849

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 Hyman Ave ST., 12 WARD)

2-FULL NAME Annie E. Haines

(a) RESIDENCE NO. 319 Hyman Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Oakley P. Haines

6 DATE OF BIRTH (month, day, and year): Feb. 1-1846

7 AGE — Years: 76 — Months: 4 — Days: 2 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm. R. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jane Hollis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Carroll E. Haines 319 Hyman Ave

15 Filed JUN 4 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921, to June 3rd, 1922, that I last saw her alive on June 3rd, 1922, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Complication of diseases
Chronic Nephritis, Valvular
Heart Trouble, General dropsy

(duration) yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary): Recent attack of La Grippe

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? Washington or Virginia

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood + urine

(Signed) Leo H. Bainum, M. D.

, 19 (Address) 21 W 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: June 6 1922

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 3631 Fallsld

Spec.—1-10-21—M&T—1500 Blks.

64850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1866 64850

1-PLACE OF DEATH Almond Home Ex Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 176 N. Broadway ST., 13 WARD)

2-FULL NAME Mrs. Jennie E. Dovell

(a) RESIDENCE NO. 729 Bay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George F. Dovell

6 DATE OF BIRTH (month, day, and year): June 4-1861

7 AGE: Years 60 | Months 11 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Page Co. Virginia

PARENTS

10 NAME OF FATHER: Isdo. Hepner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sarah McMullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Harry E. Dovell

(Address) 3516 Edmondson Ave

15 Filed JUN 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1922

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1922, to June 2, 1922.

that I last saw her alive on June 2, 1922.

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremic Convulsions.

Hypertension. Traumatic Hematoma

Right Muscle. (duration) yrs. mos — ds.

CONTRIBUTORY (Secondary) Acute Glandular Tonsilitis and Edema Lungs (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 2 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Richard G. Coblentz, M. D.

19 (Address) C. M. S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edmondson Ridge — DATE OF BURIAL: June 5, 1922

20 UNDERTAKER: Horace H. Biligue — ADDRESS: 3631 Falls Rd

TION is very important. See instructions on

D 64851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64851

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Popp.

(Residence in Baltimore: No. 902 W. Lexington St.; yrs., 56 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, January (Month) (Day), 1866 (Year)

7-AGE, 56 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

PARENTS.

9-BIRTHPLACE, (State or Country). Balto

10-NAME OF FATHER. Geo. Popp.

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Popp

(Address) 902 W. Lexington

15- Filed JUN4 - 1922 ROBERT R. KRAUTER, Registrar of Vital Statistics. Burial Permit Issued

CAUSE OF DEATH must be plainly written. Every question must be answered if possible. Omissions will cause delay. Words "Unknown" or "Not Known" are important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia Few hours

(Duration) yrs. mos. ds.

(Signed) W. J. Riley M. D.
(Coroner.)

June 3 1922 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 2 hrs yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, June 5 1922

20-UNDERTAKER Peter F. Howard Son ADDRESS 2901 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64852

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64852

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp - Balto, Md — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Buckley -

(a) RESIDENCE. No. 15 Union Ave Balto. Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~ or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32 yrs -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - 040

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER ~~Daniel~~ J. Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Foley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant University Hosp records. (Address)

15 Filed JUN 4 - 1922 ...R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 3 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1922, to June 3, 1922, that I last saw h alive on June 3, 1922, and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. 3 days

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at place of death -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) R. Dexter, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 6th 1922
20 UNDERTAKER Foley Company	ADDRESS 911 Holliday St

TION is very important. She

UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Patient entered the hospital suffering from acute alcoholism (was intoxicated) recovered from his alcoholism and developed lobar pneumonia [illegible] 4th day -

D 64853

64853 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 7

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 1104 E. Madison St. ST.: 10 WARD)

2-FULL NAME George Levin Brosick

(a) RESIDENCE. NO. 1104 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	7		

8 OCCUPATION OF DECEASED — 0d0

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Chas. L. Brosick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City

12 MAIDEN NAME OF MOTHER Elenore Dilow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Chas. L. Brosick 1104 E. Madison St.

15 Filed JUN 4 - 1922 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th. 1922

17 I HEREBY CERTIFY, That I attended deceased from May 28. 1922 to June 3rd 1922

that I last saw him alive on June 3rd 1922

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Infantile Debility (duration) — yrs. 16 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? C. T. Lebo

(Signed) C. T. Lebo, M. D.

6. 4. 1922 (Address) 1001 Forsyth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: June 5 1922

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 2211 Bangs

Be properly classified. mation should be carefully supplied, so that it may be of certificates. CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

S[illegible]—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64854 D 64854

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Municipal Hosp at Bay View REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin S. Dorsey

(a) RESIDENCE NO. 2327 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 58 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horseman

(b) General nature of industry, business, or establishment in which employed (or employer): Dr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): U Va.

PARENTS

10 NAME OF FATHER Edwin Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md U.S.A.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Chas. J. Dorsey 2327 Linden Ave

15 Filed JUN 4 - 1922 ROBERT A. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to June 3, 1922 that I last saw him alive on June 3, 1922 and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

Syphilis; (Tabes Dorsalis)

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Urinary tract infection

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Cl. Path.

(Signed) Charles McDonald, M. D.

6/4 1922 (Address) Municipal Hosp. Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: 6/6 1922

20 UNDERTAKER: W. J. Fichtner & Son — ADDRESS: Bolton Ave

CAUSE OF DEATH. See instructions on back of this CERTIFICATE. IMPORTANT. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64855

CERTIFICATE OF DEATH.

74-001 D 64855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3607 Clifton Ave., ST., 15 WARD)

2-FULL NAME Charles W. Meyer

(a) RESIDENCE NO. 3607 Clifton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dora Meyer

6 DATE OF BIRTH (month, day, and year) Sept. 7th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Theatrical Actor

(b) General nature of industry, business, or establishment in which employed (or employer) Theatrical Prof

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jost Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Germany

12 MAIDEN NAME OF MOTHER Jemimah Patchouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London, Eng.

14 Informant John L. V. Murphy

(Address) 3607 Clifton Ave

15 Filed JUN 4 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to June 3rd, 1922,

that I last saw him alive on June 2nd, 1922,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Necropsy.

(Signed) Helen F. Gilleman, M. D.

, 19 (Address) 1227 Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 5 1922

20 UNDERTAKER Wm. J. Ickes & Son ADDRESS None

CAUSE OF DEATH. See instructions on back of Certificate. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64856

CERTIFICATE OF DEATH.

91-00

D 64856

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Spalding Ave. St. 27 WARD)

2-FULL NAME James Josiah Blaney

(a) RESIDENCE NO. 411 Spalding Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Blaney

6 DATE OF BIRTH (month, day, and year) June 16-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas. N. Blaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucretia Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Caroline Blaney (Address) 411 Spalding Ave

15 JUN 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1919, to Jan 31st, 1922,

that I last saw him alive on Jan 31st, 1922,

and that death occurred, on the date stated above, at 5 a.m. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. 7 mos 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of Dead

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure

(Signed) J. Frank Willett M. D.

(Address) Reisterstown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet DATE OF BURIAL June 5 1922

20 UNDERTAKER Wm J Tuckner & Son ADDRESS N Y Pa

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

64857

D 64857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64857

D 64857

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Davis Denmeade Kolb.

(a) RESIDENCE NO..... ST., ... WARD Braddock Heights Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 18 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) HUSBAND of Zella Mealey Kolb

6 DATE OF BIRTH (month, day, and year) Dec 23, 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49.	5	12	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Stock-dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Buying & cattle.

(c) Name of employer Home.

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland

PARENTS

10 NAME OF FATHER W. Augustus Kolb.

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary A Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Johns Hopkins Hospital (Address) Baltimore Md.

15 FILED JUN 5 - 1922 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to June 4, 1922, that I last saw him alive on June 4, 1922, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — — 2 ds.

CONTRIBUTORY (Secondary) Exhaustion from delirium -

Exhaustion (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Frederick, Maryland.

Did an operation precede death? Yes Date of May 24, 1922

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Leslie B. Hohman M. D.

June 4 1922 (Address) Leslie B. Hohman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Frederick Md

DATE OF BURIAL 6/7 1922

ADDRESS Frederick Md.

20 UNDERTAKER C C Carty

ADDRESS Frederick Md.

mation should be entered in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Sub-Mucous Resection

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64858

CERTIFICATE OF DEATH.

41

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice L. Barnes

(a) RESIDENCE. No. Holabird Apts Camp Holabird ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) -1- 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) 13'

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Barnes

11 BIRTHPLACE OF FATHER (city or town) Md (State or country) — Barnes

12 MAIDEN NAME OF MOTHER — Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital records. (Address)

15 Filed JUN 5 - 1922 ROBERT R. KRAUTER, Registrar

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to June 3, 1922, that I last saw her alive on June 3, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carbuncle of upper lip.

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At her home

Did an operation precede death? Yes Date of May 31, 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) V. B. Jones, M. D.

, 19 (Address) University Hospital Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boston Mass

DATE OF BURIAL: June 5 19

20 UNDERTAKER: Harry A. Witzke

ADDRESS: 1531 W. Lombard

Spec.--1-10-21--M&T--1500 Bks.

D 64859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64859

CERTIFICATE OF DEATH.

REGISTERED NO. 162

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kilbourn

(a) RESIDENCE NO. St. Agnes Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-3-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Infant				6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER Andrew Carroll Kilbourne

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)

12 MAIDEN NAME OF MOTHER Sophie C. Lenard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant M. A. Fulbourne (Address) 2484 W. Fayette St

15 JUN 5 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to June 4, 1922, that I last saw her alive on June 4, 1922, and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Concussion

atelectasis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. W. Scott M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL June 5 1922

20 UNDERTAKER Jos Joerden & Son ADDRESS 2178 Pres.

CAUSE OF DEATH. See instructions on back of ... TION is very important.

D 64860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C 188-003

D 64860

1-PLACE OF DEATH

City of BALTIMORE: (No. Northern Bridge St. Between Jones Falls & Falls Rd Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Stotts.

(Residence in Baltimore: No. 1530 Mt. Royal Ave. St.; 12 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	single

6-DATE OF BIRTH. Jan. (Month) (Day) 1910 (Year)

7-AGE. 12 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Harry S. Stotts

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Anna Emmert

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry S. Stotts,

(Address) 1530 Mt. Royal Ave.

15-

Filed JUN 5 - 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and the verdict of the jury find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
automobile accident
(Duration) yrs. mos. ds.
Instant death

~~CONTRIBUTORY~~ (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

June 5, 1922 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge DATE OF BURIAL. June 5- 1922

20-UNDERTAKER. John O. Mitchell ADDRESS 1201 N. Fayette St.

is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

15 D 64861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64861

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: 11 WARD) 100-C

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B. Grossman

(a) RESIDENCE. NO. Mt. Royal Apts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Oct 15 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Anthony Grossman

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Helen E. Griffith

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.

(Address) Susan R. Grossman Mt Royal

15 Filed JUN 5 - 1922 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 - 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 3, 1922, that I last saw h alive on June 3, 1922, and that death occurred, on the date stated above, at 1 55 P m.

The CAUSE OF DEATH* was as follows: Pneumonia, broncho

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Carbuncle of back

(duration) yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of June 2 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	June 5 1922

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

001

D 64862

REGISTERED NO. 99 D 64862

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 W. Pratt ST. 20 WARD)

2-FULL NAME Mary S Frey

(a) RESIDENCE. NO. 1908 W Pratt ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George W Frey

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto County Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mrs Geo W. Frey (Address) 1908 W. Pratt St

15 Filed JUN 5 - 1922 ROBERT N. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1/22 19

17 I HEREBY CERTIFY, That I attended deceased from 7/30/21, 19..., to 6/1/22, 19..., that I last saw h... alive on 5/31/22, 19..., and that death occurred, on the date stated above, at 11 3/4 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) F W Wisner M. D.

6/2, 19 22 (Address) 1302 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 5 1922
20 UNDERTAKER	ADDRESS
Henry Lutz	1203 N. Broadway

TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64863

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 N. Dallas ST. 18 WARD)

2-FULL NAME Pauline Weller

(a) RESIDENCE No. 1323 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Karl Weller

6 DATE OF BIRTH (month, day, and year): Jan 31 1862

7 AGE: Years 60 Months 4 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fred. Eberspacher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Spleth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Karl Weller

(Address): 1323 N. Dallas St.

15 Filed JUN 3 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3rd 9 A.M. 1922, to June 3 1922, 7.30 P.M.

that I last saw her alive on June 3 1922

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH was as follows:

Chronic Organic Heart disease

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Hattie B. A. Meyer, M. D.

(Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mathews Cem — DATE OF BURIAL: June 6 1922

20 UNDERTAKER: Frank A. Fink — ADDRESS: 915 N. Gay

CAUSE OF DEATH. See instructions on back of Certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64864 64864

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH 408 Norman Ave.

REGISTERED NO.

CITY OF BALTIMORE: (NO. Edward Woods ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 408 Norman ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred aft 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Woods

6 DATE OF BIRTH (month, day, and year) Jan 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Frank Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank Woods (Address) 408 Cathedral Corner

15 Filed JUNE 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of this certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1922, to June 2, 1922, that I last saw h[illegible] alive on June 1, 1922, and that death occurred, on the date stated above, at 4 A1 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis. Hypertrophy of Cardiac & Interventricular

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) J. F. Flynn M. D.

6/5 1922 (Address) 804 Albemarle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 6 1922

20 UNDERTAKER Margaret D. Flynn — ADDRESS 1711 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

155612.
D 64865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 64865

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gundy

(a) RESIDENCE. No. 1505 N. Carey St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Un Known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Catherine Spinard (consort)

6 DATE OF BIRTH (month, day, and year) Dec.? 1887.

7 AGE: Years 34 Months 5 Days ? If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Ben Gundy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Winnie Baylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 JUN 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 3, 1922, that I last saw h[illegible] alive on June 3, 1922, and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchopneumonia)

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? 1505 N. Carey St.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) E. Cowles Andrus, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: June 5 1922

20 UNDERTAKER: James J. Dunn — ADDRESS 1303 Druid Hill Ave.

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

156174 D 64866

HEALTH DEPARTMENT—CITY OF BALTIMORE D 64866

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(No. JOHNS HOPKINS HOSPITAL ST.: 24 WARD)

2-FULL NAME Margaret Johnson.

(a) RESIDENCE. NO. 1511 Webster St. City. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. (unknown) mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or ~~WIFE OF~~) late Andrew H. Johnson

6 DATE OF BIRTH (month, day, and year) Oct 2, 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Del.

PARENTS

10 NAME OF FATHER Isaac Kitchens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Eliza Scott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed JUN 5 - 1922, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to June 4, 1922, that I last saw her alive on June 4, 1922, and that death occurred, on the date stated above, at 5:5 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, myocardial insufficiency, auricular fibrillation

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism; pulmonary edema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Girdletree Worchester Co. Md.

DATE OF BURIAL 6/7 1922

20 UNDERTAKER Philip Herrig

ADDRESS 2016 Orleans St.

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64867

CERTIFICATE OF DEATH.

D 64867

REGISTERED NO. 187-100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 N. Schroeder ST., 18 WARD)

2-FULL NAME Richard W. Calligan

(a) RESIDENCE NO. 312 N. Schroeder ST., 18 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/28/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Guy A. Calligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna E. Rice

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Guy A. Calligan (Address) 312 N. Schroeder St

15 Filed JUN 5 - 1922, 19 ROBERT A. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 19 22, to June 4, 19 22, that I last saw h alive on June 4, 19 22, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos 8 dy.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. A. Fair, M. D.

, 19 (Address) 12 E Eu

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL June 5 1922

20 UNDERTAKER George J. Smith — ADDRESS, 00 & Fayette

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—I-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64868

CERTIFICATE OF DEATH.

84 D 64868

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes' ST. Hospital

2-FULL NAME Hamilton Atkinson

(a) RESIDENCE NO. 322 N. Fulton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 3 | Months | Days | If LESS than 1 day, hrs. or min.: Don't know

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: H. P. Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cannot Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " " "

14 Informant: H. P. Atkinson

(Address) 322 N. Fulton

15 Filed JUN 5 — 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-4 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-26, 1922 to 6-4, 1922

that I last saw him alive on 6-4, 1922

and that death occurred, on the date stated above, at 6:01 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial pressure probably due to tumor

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unimproven

Did an operation precede death? Date of June 3, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Scott, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 6-6 1922

20 UNDERTAKER: James. Dignan & Son

ADDRESS: 1004 E Lexington St

CAUSES OF DEATH: See instructions on back of Certificate. ATTENTION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64869

CERTIFICATE OF DEATH.

D 64869

18 161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 881 Robert ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Haley

(a) RESIDENCE. NO. 881 Robert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 31-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Haley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Effie Silghmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) James Haley 881 Robert St

15 Filed JUN 5 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/31 1922 to June 3 1922, that I last saw h[e] alive on June 3 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Premature Labor (7 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Bedside

(Signed) J. Lum Worley, M. D.

6/5 1922 (Address) 908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 5 1922
20 UNDERTAKER John H Toadvine	ADDRESS 1027 Druid Hill Ave

TION is very important. See instructions on back

Spec.—1-10-21 M&T 1509 Bks.

D 64870 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64870

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 W. Cross ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Short

(a) RESIDENCE NO. 514 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced, (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura S Short

6 DATE OF BIRTH (month, day, and year) [illegible] 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) D D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Saml Short

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Sydie Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Frances Hall (Address) 514 W. Cross St

15 Filed JUN 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/29/22, 1922, to 6/4/22, 1922, that I last saw him alive on 6/4/22, 1922, and that death occurred, on the date stated above, at 1.25 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Nephritis Chronic, 1

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fat. Dc. Parenchymatous Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical microscopical

(Signed) J. Sam Bradley, M. D.

6/5/22 (Address) 908 S Shady St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL June 6 1922

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill ave

CAUSE OF DEATH. See instructions on back of Certificate. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

(Windhauer)

D 64871 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64871

1-PLACE OF DEATH Bayview Hospital 179 REGISTERED NO.

CITY OF BALTIMORE: (No. 76 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Windhauer

(a) RESIDENCE NO. Bayview asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Barbara Windhauer

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 63; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 140

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hospital Record

15 Filed JUN 5 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/2/22 19

17

I HEREBY CERTIFY, That I attended deceased from 6/1/22, 19, to 6/3/22, 19, that I last saw h in alive on 6/3/22, 19, and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

, 19 (Address) Bayview Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: June 6 1922

20 UNDERTAKER: John Ulrich — ADDRESS: 210 Eastern

TION is very important. See instructions on back of certificate.

Dec.—6-9-19—H. P. Co.—1900 Bks.

D 64872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 5946 D 64872

159-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL, ST.: (WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Cherill F. W. Bell.

(a) RESIDENCE. NO. Tonry Bay, Wellington ST., New Zealand, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: G. W. W. Bell, Father.

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1.	3.	15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): New Zealand.

PARENTS

10 NAME OF FATHER: Cherill Bell.

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Zealand

12 MAIDEN NAME OF MOTHER: Dorothy M. Newton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Zealand

14 Informant: JOHNS HOPKINS HOSPITAL, (Address) Records

15 FILED JUN 5 - 1922 ROBERT R. KRAUER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 7, 19 22 to June 3, 19 22, that I last saw him alive on June 3, 19 22, and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

Obstructive form

(duration) yrs. 13 mos. — ds.

CONTRIBUTORY (Secondary) operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 3.

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Jay McKeaver, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemet. DATE OF BURIAL: June 5 '22

20 UNDERTAKER: H. E. Hughes ADDRESS 4248 Reisterstown Rd.

TION is very important. See instructions

D 64873 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64873

CERTIFICATE OF DEATH.

Registered No. C 16129

1-PLACE OF DEATH

City of BALTIMORE: (No. 924 N. Stricker St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Tappimp

(Residence in Baltimore: No. 924 N. Stricker St. St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

6-DATE OF BIRTH, about 1853
(Month) (Day) (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Geo. Talbot

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Wk

13-BIRTHPLACE OF MOTHER, (State or Country). Wk.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah D. Martin

(Address) 924 N. Stricker St.

15- JUN 5 - 1922 192 S. E. Wehn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 3, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Cerebral Hemorrhage~~
Chr. Interstitial Nephritis
(Duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) no history
(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)
June 5 1922 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL. 6/5/22 19

20-UNDERTAKER. Sam. W. Chasanow — ADDRESS [illegible]

IS VERY IMPORTANT. USE INK.

D 64874 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64874

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. 515 Eutaw St., 1 Ward) Registered No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Bokern

(Residence in Baltimore: No. 515 Eutaw St., yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Jan (Month) 27 (Day) 1853 (Year)

7-AGE: 69 yrs. 4 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Fisherman (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Fredrick Bokern

11-BIRTHPLACE OF FATHER. (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Harriet Williams

13-BIRTHPLACE OF MOTHER. (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bokern

(Address) 2713 Eastern ave

15- JUN 5 - 1922 192 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 4 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

192 (Address)

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Ock Lawn Cemt. DATE OF BURIAL: June 6 1922

20-UNDERTAKER: Libby Zuber ADDRESS 403 S. Wolfe

N. B.—Every item of information should be given as far as possible, so that it may be properly classified. Exact statements are required in state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are required in every case of certificate. This is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64875

CERTIFICATE OF DEATH.

+45

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. St. Joseph's Hospital ST.: 9 WARD)

2-FULL NAME Elizabeth Barron.

(a) RESIDENCE. NO. Old County Road near Pikesville WARD. Md (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 mos. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52	—			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co (State or country) Md

PARENTS

10 NAME OF FATHER Edward Barron

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Kilbannon

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. Mary Barron (Address) Old County Road near Pikesville Md

15 JUN 5 1922 19 ROBERT P. KRAUTER Registrar

Burial Permit Clerk, Hauer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24 1922 to June 4 1922

that I last saw her alive on June 4 1922

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Rectum (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 4/1922

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Harold C. Pillsbury, M. D.

19 (Address) 4,5 Cedarcroft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemy

DATE OF BURIAL June 6 1922

20 UNDERTAKER Henry Hoch Son

ADDRESS 1301 Eutaw St

TION is very important. See instructions

Spec.—1-10-21—M&T—1500 Bks.

D 64876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64876

32

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 S Exeter ST., 3 WARD)

2-FULL NAME Elizabetta Trevissono

(a) RESIDENCE NO. 207 S Exeter ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Trevissono

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosario Borrolio

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Joseph Trevissono
(Address) 207 S Exeter St

Filed JUN 5 - 1922 ROBERT M. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to June 4, 1922, that I last saw her alive on June 4, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Meningitis
(possible Tuberculous)

(duration) ..... yrs. 1 mos. 15 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Victor P. Lombardo, M. D.

, 19 (Address) 232 S. High St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 7 1922
20 UNDERTAKER	ADDRESS
Randall Dysel & Son	37 St.

CAUTION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

64877. HEALTH DEPARTMENT—CITY OF BALTIMORE 7400 D 64877.

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 E. Monument ST., 7 WARD)

2-FULL NAME Patsy Gossett.

(a) RESIDENCE NO. 1611 E. Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE: Years 56yrs Months Days

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Halifax Co Va

PARENTS

10 NAME OF FATHER: Jacob Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Kentnonnt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Mollie Howard (Address): 1611 E. Monument St

15 Filed JUN 5 1922 19.. Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-2-1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to June 2, 1922, that I last saw her alive on June 1, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 48 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Indigestion.

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. H. Cargill, M. D.

6-3-1922 (Address) 611-N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL 1922

20 UNDERTAKER: Samuel P. Hemsley

ADDRESS 578 N. Biddle

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64878

CERTIFICATE OF DEATH.

90 D 64878

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 E. Montgomery ST., 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles G. Kieper

(a) RESIDENCE NO. 20 E. Montgomery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Lillian C. Kieper

6 DATE OF BIRTH (month, day, and year) Mar, 14, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	38	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber.

(b) General nature of industry, business, or establishment in which employed (or employer) unable to

(c) Name of employer work for last 3 years

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John G. Kieper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary S. Hochning

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Paul C. Kieper

(Address) 1314 S. Eight St

15 Filed JUN 5 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr, 10, 1918, to June, 3, 1922, that I last saw ~~him~~ alive on June, 3, 1922, and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis, myocarditis, Hypertension (Cause, negative)

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dave Franklin, M. D.

6/6, 1922 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL June 6 1922

20 UNDERTAKER F. A. Isaacs & Son

ADDRESS 703 Hanover St

TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

D 64879

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 64879

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Wilkens Ave. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Josiah Jones

(a) RESIDENCE NO. 1725 Wilkens Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lavinia Jones

6 DATE OF BIRTH (month, day, and year) Nov. 15" 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	6	19	

8 OCCUPATION OF DECEASED

006

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel
(State or country) Md.

PARENTS

10 NAME OF FATHER James J. Jones

11 BIRTHPLACE OF FATHER (city or town) Howard Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Kine

13 BIRTHPLACE OF MOTHER (city or town) Marlboro
(State or country) Calvert Co., Md.

14 Informant Mrs. Lavinia Jones
(Address) 1725 Wilkens Ave.

15 Filed JUN 5 - 1922. ROBERT P. KRAUTER, Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3" 1922

17

I HEREBY CERTIFY, That I attended deceased from May — , 1917 , to June 3 , 1922 ,

that I last saw him alive on June 3 , 1922 ,

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas A Schaefer M. D.

June 3" 1922 (Address) 53. S Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL June 6" 1922

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N Bulls St

IMPORTANT. See instructions on back of this CERTIFICATE

Spec.—1-10-21—M&T—1500 Bks.

D 64880

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 64880

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 West Baltimore St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto F. Fischer

(a) RESIDENCE No. 1806 West Baltimore St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9th. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Lauer's Dept. Store

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Fischer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Marx

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Herman J. Fischer
(Address) 1806 West Baltimore St.

15 Filed JUN 5 - 1922 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1922, to June 2nd, 1922,
that I last saw him alive on June 1st, 1922,
and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis - Emphysema

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Phlebitis —

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. J. Gibbs, M. D.

6/4, 1922 (Address) 6222 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 5 1922
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W. Balto St

TION is very important. See instructions on back of Certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kenney.

D 64881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 16 100-206 64881

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 N. Carey ST.: ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Kenney

(a) RESIDENCE. NO. 1121 N. Carey ST., WARD. Pennsylvania
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~in the City 9 months~~
(State or country) Penna

PARENTS

10 NAME OF FATHER Kenney, Jenny.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Jones.

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant Jennie Kenney
(Address) 1121 N. Carey St.

15 Filed JUN 5 — 1922 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2 — , 1922, to June 3 , 1922,
that I last saw him alive on June 3 , 1922,
and that death occurred, on the date stated above, at 10-P. m.
The CAUSE OF DEATH* was as follows:

Broncho — pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. T. McCarthy, M. D.

, 19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cherridal. Cem.

DATE OF BURIAL June 6 19..

20 UNDERTAKER Joseph A. Farrell.

ADDRESS 2311 Pine St.

TION is very important. See instructions on back of

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No autopsy

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64882

CERTIFICATE OF DEATH.

×32 D 64882

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Amos

(a) RESIDENCE NO. 0 City Home Catonsville Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 608

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Margaret Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Hospital Rec'd
(Address)

15 Filed JUN 5 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1 1922 to June 3 1922

that I last saw him alive on June 3 1922

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Lumbar Pott's Disease

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. A. McKeon M. D.

. 19 (Address) Mayrille Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 6/6 1922

20 UNDERTAKER Williams Cook

ADDRESS 502 E North

TION is very important. See instructions on back of Certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64883

D 64883

162

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 Forest ST. 10 WARD)

2-FULL NAME Wallace John Bueker

(a) RESIDENCE. NO. 1140 Forest ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 4-22

7 AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ball Md

PARENTS

10 NAME OF FATHER: John J. Bueker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Hebe Anderson 6-5-22

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant (Address): John J. Bueker 1140 Forest Ave

15 FILED JUNE 6 - 1922 ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 4, 1922

that I last saw him alive on June 4 1922

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Livida

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. E. Rumbaeck M. D.

(Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gth. G Rohrer MD S.B. Health	Jun 5 1922
20 UNDERTAKER	ADDRESS

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64884

CERTIFICATE OF DEATH.

89 D 64884

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Eutaw St., (WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Brown

(a) RESIDENCE NO. 2203 Eutaw Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Asher Brown

6 DATE OF BIRTH (month, day, and year): Nov. 27 1840

7 AGE — Years: 81 — Months: 6 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. R. Goldheim

(Address): 2203 Eutaw Place

15 JUN 5 - 1922

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/4/22.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 4, 1922, that I last saw her alive on June 4, 1922, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris. Acute Cardiac Dilatation. Myocarditis.

(duration) 16 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Chronic Kidney Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pain, Nurses Notes

(Signed) Louis Neufeld, M. D.

, 19 (Address) 2700 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 6/6/1922

20 UNDERTAKER: David Goldheim

ADDRESS: 118 W. Mt. Royal Ave.

CAUSE OF DEATH. See instructions on back of certificate. IMPORTANT. See instructions on back of certificate. IMPORTANT. See instructions on back of certificate. IMPORTANT

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64885

CERTIFICATE OF DEATH.

47

D 64885

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 Linden Ave ST.: 11 WARD)

2-FULL NAME Margaret Neely

(a) RESIDENCE. NO. 1316 Linden Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos. H. Neely

6 DATE OF BIRTH (month, day, and year): Aug 8- 1878

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
43	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: John Catenson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Margaret Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Jos. H. Neely 1316 Linden ave

15 Filed JUN 5 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1921, to June 3, 1922, that I last saw h[illegible] alive on June 3, 1922, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinomatosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 6 mo ago

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo. M. Settle, M. D.

6/4 1922 (Address) 243 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: June 6 1922

20 UNDERTAKER: Chas. E. Evans & Son. — ADDRESS: 118 W. Mt. Royal

TION is very important. See instructions on

D 64886 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.V.Hospital #56. 24 1885 Registered No. C.....

City of BALTIMORE: (No. Fort McHenry. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Franz. 29 ----------

(Residence in Baltimore: No. Edward & Furley Aves. Raspburg. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE. 29 yrs. ---------- mos. ---------- ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: 2nd. class
(b) General nature of industry, business, or establishment in which employed (or employer): Electrician, Navy.

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Franz.

11-BIRTHPLACE OF FATHER. (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER. (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Nagel. (cousin)

(Address) Raspourg.

15- Filed JUN 5 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3rd. 1922. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held nn inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to nts death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall down Elevator shaft

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

June 4. 192.2. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Lorraine Cemt. DATE OF BURIAL. June 6. 1922

20-UNDERTAKER. A. Lauer & Bro. ADDRESS 1127 E Balto. St.

Is Very Important. See Instructions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64887

REGISTERED NO. 6-10

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1027 N Mount ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Tolton

(a) RESIDENCE. NO 1027 N Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Negro	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1 yr 2 mo	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Tolton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Richard Tolton
(Address) 1027 N Mount St

15 Filed JUN 5 - 1922, 19.... ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4/1922

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1922, to June 4, 1922, that I last saw h[illegible] alive on 6/4/1922, and that death occurred, on the date stated above, at 3 20 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

4 da (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) measles

Will (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm R. Boykin, M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 6 1922

20 UNDERTAKER James H. Davis

ADDRESS 1200 Greenmount

TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

64888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 64888

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1543 Aisquith ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Blake

(a) RESIDENCE NO. 1543 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine McGraw

6 DATE OF BIRTH (month, day, and year): Mar. 31, 1848

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or min.
	74	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ladder - man

(b) General nature of industry, business, or establishment in which employed (or employer): Balto. City

(c) Name of employer: Fire Department

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John W. Blake

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Flynn

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant (Address): James H. Blake 1543 Aisquith Street

15 Filed: JUN 5 - 1922 ROBERT N. KRAUTER. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to June 3rd, 1922, that I last saw him alive on June 2nd, 1922, and that death occurred, on the date stated above, at 11.05 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell M. D.

, 19 (Address) 1516 N. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 6/6, 1922

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: N. Calvert

CAUTION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64889

CERTIFICATE OF DEATH.

44

REGISTERED NO. C 64889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Warren ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Woods

(Residence in Baltimore: No. 727 Warren St.; 22 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, March 6th (Month) (Day), 1879. (Year)

7-AGE, 43 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Brewer 180
(b) General nature of industry, business, or establishment in which employed (or employer) Brewery or Tavern

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, William Harper

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Matilda Grayson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father Woods

(Address) 1112 Riggs Av

15-
Filed JUN 5 1922 191.... ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3d (Month) (Day), 1922. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16th 1922, to June 3d 1922, that I saw h.. alive on May 31 1922, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis and Carcinoma

Peritonitis

(Duration) — yrs. 7 mos. — ds.

CONTRIBUTORY Peritonitis & Ulceration of Colon
(Secondary)

(Duration) — yrs. 1 mos. — ds.

(Signed) Edward Eellaskunzie M. D.

June 5th, 1922 (Address) 1339 Wash Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	June 6, 1922
20-UNDERTAKER	ADDRESS
George H. Helland	1631 Lemmon Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64890

CERTIFICATE OF DEATH.

REGISTERED NO. 27179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 2714 Belair Rd ST.: WARD)

2-FULL NAME John Collins

(a) RESIDENCE. No. 2714 Belair Rd ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances A. Collins

6 DATE OF BIRTH (month, day, and year) Dec 25 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75 yrs	5	16,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Betty Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

t4 Informant (Address) Betty Eisenhart 2714 Belair Rd

15 Filed ..., 19... Robert P. Harrison, Registrar

N5 - 1922 Burial Forest Park

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1922 to June 5, 1922.

that I last saw him alive on June 5, 1922.

and that death occurred, on the date stated above, at 12 10 M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 10 yrs. mos. ds.

t8 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/2/22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bruce Hirsh M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

t9 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	June 7. 1922
20 UNDERTAKER	ADDRESS
William Cook	502 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 64891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64891

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Boyce

(a) RESIDENCE NO. 1005 W. Booth St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Hospital Records.	52 (?)	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Ison Boyce

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant (Address): Hospital Records, Municipal Hospital.

15 June 25 - 1922, 19 ... Registrar: Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 13, 19 22, to June 2, 19 22, that I last saw him alive on June 1, 19 22, and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Cachexia carcinomatosa

Unknown Duration (duration) ... yrs. ... mos. 2 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ...

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

6/2/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 6 1922
20 UNDERTAKER	ADDRESS
Brown & Ireland	Schroder

TION is very important. See instructions on back of certificate.

Dec 9 saw pt.

Spec.—1-10-21—M&T—1500 Bks.

D 64892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64892

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH Church

CITY OF BALTIMORE: (No.) Broadway ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Holland

(a) RESIDENCE No. 1737 Bradford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): July 29 1878

7 AGE — Years: 43 Months: 10 Days: 7 If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joshua Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Albert E Holland

(Address): 1737 Bradford st

15 Filed ..... 19 ..... Registrar

Robert P Carrigan

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to May 31, 1922, that I last saw h[illegible] alive on May 31, 1922, and that death occurred, on the date stated above, at 4:15 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Encephalitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Picture

(Signed) Richard J. Cobleutz, M. D.

, 19 (Address) 202 S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: June 6 1922

20 UNDERTAKER: John Fields — ADDRESS: 1200 W Lombard

TION is very important. See instructions on back of certificate.

3-1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64893

CERTIFICATE OF DEATH.

101-00 D 64893

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N Gilmor ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Albert-Cougnet

2-FULL NAME 414 N Gilmor

(a) RESIDENCE NO. 414 N Gilmor ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Emil Cougnet

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mary Hedinger

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Emil Cougnet (Address) 414 N. Gilmor St

15 Robert F ..... 19 ..... Registrar

Burial Permit Issued

5-1922

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to June 5, 1922, that I last saw h... alive on June 4, 1922 and that death occurred, on the date stated above, at 4th A. m.

The CAUSE OF DEATH* was as follows: Cardiac Failure

Pulmonary Tuberculosis (duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia, Pneumococcus Meningitis (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jno. H. Heidenberger M. D.

6/5, 1922 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 6 1922

20 UNDERTAKER John J. Fields — ADDRESS 1700 W Lombard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64894

CERTIFICATE OF DEATH.

31 D 64894

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 N. Washington ST., 8 WARD)

2-FULL NAME Louisa E. Smith

(a) RESIDENCE NO. 1934 N. Washington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Frederick H. Smith

6 DATE OF BIRTH (month, day, and year) March 15th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER William H Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Joyce

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs Gertrude E. Keiner (Address) 1934 N. Washington st

15 6-5 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4 1922

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1922 to June 4, 1922

that I last saw her alive on June 3, 1922

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis (duration) yrs. 3 mos. ds.

Mitral Regurgitation

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Acute Edema of Lungs (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Murphy, M. D.

6-4-22 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 7th 1922
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64895

CERTIFICATE OF DEATH.

REGISTERED NO. 74001

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 665 (ST.) Sterling (WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Feeney

(a) RESIDENCE. NO. 665 ST., Sterling WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary J. Feeney

6 DATE OF BIRTH (month, day, and year) Oct 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Feeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mary J. Feeney 665 Sterling St

15 [illegible], 19 Registrar

TION is very important. See instruction

N5 - 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922, to June 3, 1922, that I last saw h~~im~~er alive on June 2, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis J. Faill, M. D.

6/6, 19 22 (Address) 936 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 6th 1922
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64896

D 64896

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Light St. ST.: 23 WARD)

2-FULL NAME Charles H. Roberts

(a) RESIDENCE. NO. 1306 Light ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bertha Roberts

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired custom house official

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. R. Roberts

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Voyce

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Bertha Roberts
(Address) 1306 Light St.

15 Filed ..... 19 ..... Registrar

5-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1922, to June 3, 1922,
that I last saw him alive on June 3, 1922.
and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
Chronic interstitial nephritis
unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) yrs. mos. 11 d.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. phys.

(Signed) Wm. E. Stigler, M. D.

6/5 1922 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	6/6 1922
20 UNDERTAKER	ADDRESS
Jos. F. Lakey & Sons	1316 Light St

TION is very important. See instructions on

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64897

D 64897

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5331 Pimlico Ave. (WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Scanlan

(a) RESIDENCE. NO. 5331 Pimlico Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —— 1835

7 AGE: Years 86 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Dicky Scanlan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: D. Scanlan
(Address) 5331 Pimlico Ave

15 Filed June 19 P. Harrison Registrar

5—1922

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1922, to June 3, 1922, that I last saw him alive on June 2, 1922, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer.
Carcinoma of the
Rectum. Started in Perirectal
glands (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic.

(Signed) G. N. Brodney, M. D.

, 19 (Address) 126 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Ridge

DATE OF BURIAL: 6/6 1922

20 UNDERTAKER: J. Sidney Sloan

ADDRESS 131 S Eighth St.

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

WROTEN

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64898

CERTIFICATE OF DEATH.

179

D 64898

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 W. Randall ST., 23 WARD)

2-FULL NAME Albert C. Wroten 75

(a) RESIDENCE NO. 1214 W. Randall ST., 23 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Wroten

6 DATE OF BIRTH (month, day, and year): — — 1867

7 AGE: Years 55; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman 016

(b) General nature of industry, business, or establishment in which employed (or employer): Shipbldg

(c) Name of employer: Co.

9 BIRTHPLACE (city or town) (State or country): Falls Pt.

PARENTS

10 NAME OF FATHER: Benj. Wroten

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Eliz. Hatton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co.

14 Informant: Alice A. Davies

(Address) 1214 W. Randall St.

15 6-5-1922 Robert P. Harrison, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/28/22, 19 ..., to 6/2/22, 19 ..., that I last saw h... alive on June 3, 1922, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ... yrs. 0 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... M. D.

6-6, 19 (Address) 1214 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 6/6 19...

20 UNDERTAKER: John J. Fahey & Sons

ADDRESS 1318 Light St

TION is very important. See instructions on back of Certificate.

25-1922

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

15067 D 64899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64899

CERTIFICATE OF DEATH.

129 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (St.:) 3 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Frank May

(a) RESIDENCE. No. 240 S. Caroline St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 - ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thomas May

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Gladwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to June 3, 1922, that I last saw him alive on June 3, 1922, and that death occurred, on the date stated above, at 5.05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Uremia

Hypertension, Cardiac Hypertrophy and Dilatation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. Finney Maxwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL June 19 22

20 UNDERTAKER Joseph Abrey — ADDRESS 221 N. [illegible]

TION is very important. See instructions

5-1922

Burial Permit Clerk

D 64900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64900

CERTIFICATE OF DEATH.

118 002

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Washington

(Residence in Baltimore: No. 943 Franklin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE, 28 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Q & O

9-BIRTHPLACE, (State or Country): N. C

PARENTS.

10-NAME OF FATHER, Henry Washington

11-BIRTHPLACE OF FATHER (State or Country): S. C.

12-MAIDEN NAME OF MOTHER: Mary Saunders

13-BIRTHPLACE OF MOTHER (State or Country): S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. Partlo

(Address) Curtis Bay

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

Burial Permit Clerk

6 - 1922

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstruction of Intestines

Fredrys (Duration) ....s yrs. mos. ds.

CONTRIBUTORY (Secondary) Arb. Peritonitis

(Duration) yrs. mos. ds.

(Signed) M. Ruly M. D. (Coroner.)

June 6, 1922 (Address) 165 E Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Greenmount

DATE OF BURIAL, June 6, 1922

UNDERTAKER: Robert E Hellins

ADDRESS: 1106 Ashland av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64901

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

D 64901

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 131 W. Astend ST.; 23 WARD)

2-FULL NAME Mary F. Buckmaster

(a) RESIDENCE. NO. 131 W. Astend ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris M. Buckmaster

6 DATE OF BIRTH (month, day, and year) July 4th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Talbot County (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot County

12 MAIDEN NAME OF MOTHER Sarah Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot County

14 Informant Morris M. Buckmaster
(Address) 131 W. Astend St.

15 Filed ....., 19.... Robert F. Harrison, Registrar
Deputy Clerk.

N5 - 1922

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1922

17

I HEREBY CERTIFY, That I attended ~~deceased~~ from September 22nd 1921, to June 4th 1922, that I last saw her alive on June 3rd 1922 and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of peritoneum, intestines, and rectum

(duration) 1 yrs. 4 mos. 26 ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) — yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of Feb. 23rd 1921

Was there an autopsy? Not

What test confirmed diagnosis? X-ray and operation

(Signed) Harry Heibel, M. D.

6/5, 1922 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 7th 1922
20 UNDERTAKER E. Schlosman Sons	ADDRESS 1034 Hanover St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64902

D 64902

CERTIFICATE OF DEATH.

REGISTERED NO. 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1211 Brevard ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Williams

(a) RESIDENCE. NO. 1211 Brevard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal.	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rachel Williams

6 DATE OF BIRTH (month, day, and year) Apr. 16, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38	—	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Ben Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Rachel Williams (Address) 1211 Brevard St

15 Filed ..., 19... Registrar

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1922, to June 4, 1922, that I last saw him alive on June 3, 1922, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 4m. yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelleaux, M. D.

6/13, 1922 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL King Wm. Co Va. DATE OF BURIAL 1922

20 UNDERTAKER Samuel T. Hemsley ADDRESS, 578 N. Biddle

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Louisa Baltz)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64903 D 64903

CERTIFICATE OF DEATH.

48

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 862 W Fayette ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Baltz.

(a) RESIDENCE. No. 862 W. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonhardt Baltz

6 DATE OF BIRTH (month, day, and year) Oct 8 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Rabbe

11 BIRTHPLACE OF FATHER (city or town) Hessen (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa M. Dapp

13 BIRTHPLACE OF MOTHER (city or town) Marburg (State or country) Germany

14 Informant Mary Schuler

(Address) 562 W. Fayette St

15 Filed . 19 Registrar

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 17. 1918. 19 . to June 4 . 1922.

that I last saw h er alive on June 4 . 1922

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Small Round Cell Sarcoma Nasal Fossae.

(duration) 3 yrs. 7 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam.

(Signed) Jas L. Hooper, M. D.

66. 15 E. (Address) 346 E. 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 6. 1922
20 UNDERTAKER	ADDRESS
Mrs John H. Deufel & Son	801 W. Fayette St

TION is very important. See instructions on back

D 64904

(Morgan) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64904

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2235 W. Lexington St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Mary E. Morgan

(Residence in Baltimore: No. Home of the Aged Record St. Frederick Md. St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	Widowed

6-DATE OF BIRTH. July 13 (Month) (Day) 1837 (Year)

7-AGE. 84 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE, (State or Country) Frdk- Md.

PARENTS.

10-NAME OF FATHER, George Hoskins

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Gephart

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie M. Miller

(Address) 330 N. Market St. Frederick Md

15-

Filed Nov 15 1922 Robert P. Harri[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

Arterio Sclerosis

CONTRIBUTORY (Secondary) (Duration) 5 yrs. mos. ds.

(Signed) James M. Fenlon M. D.

(Coroner.)

June 5 1922 (Address) 700 E Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt. Olivet - Frederick Md June 6 1922

20-UNDERTAKER, ADDRESS

Mrs. Mrs J. W. Zepfel & Son 901 W. Fayette

Is very important. See instructions on

1922 Burial Permit [illegible]

Spec.—1-10-21—M&T—1500 Bks.

D 64905 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64905

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Harlen ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Moore Elphinstone.

(a) RESIDENCE NO. 1710 Harlem ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank M. Elphinstone

6 DATE OF BIRTH (month, day, and year): Sept 24, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Octavia Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Lewis E. Elphinstone 1703 Eutaw Ave

15 Filed 19 Robert F. Harrison, Registrar

Burial Permit 1922 Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 3, 1922,

that I last saw her alive on June 3, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Aortic incompetence

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Bruun and Hurd, M. D.

6/5, 1922 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 6/6 1922

20 UNDERTAKER: Wm. J. Jeckins & Son

ADDRESS: North & Pennsylvania

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

D 64906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH First house north of Emmorsburg

CITY OF BALTIMORE (No. Swann Ave ST.: 23 WARD) REGISTERED No. C

2-FULL NAME Katherine Williamson Justi

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Swann Ave St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, June (Month) 19 (Day), 1873 (Year)

7-AGE, 48 yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Queen Anne Co Md

PARENTS.

10-NAME OF FATHER, Chas. H Williamson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary R. Price

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. D. Clay

(Address) Swann Ave

15- Robert P. Harrison, ..., 191.... Burial Permit Clerk. Registrar.

5-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 5 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....inquest.... (Inquest, autopsy or inquiry) find that said deceased came to ....his.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

[redacted] myocardial degeneration

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) J. T. Hennessy

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

June 5, 1922 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Centreville. Md | DATE OF BURIAL, June 7, 19 22

20-UNDERTAKER Wm. D. Tuckers Sons | ADDRESS N. Pa

CAUSE OF DEATH. Every item must be answered. If unknown, state the fact. Be particular and definite. Do not use indefinite terms. Name the disease causing death, not the symptoms. If from violence, state the means and whether accidental, suicidal or homicidal. If from accident, state where it occurred. If from suicide, state the motive, if known. If from homicide, state the name of the criminal, if known. If from a casualty, state the circumstances. If from a disease, state when the patient was last seen alive. If from a disease, state when the patient was last seen alive. If from a disease, state when the patient was last seen alive

Spec.—1-10-21—M&T—1500 Bks.

D 64907

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 D 64907

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3806 Bonner Road ST.) (12 WARD)

2-FULL NAME Edith Virginia MacLellan

(a) RESIDENCE NO. 3806 Bonner Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 3 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER R. Charles MacLellan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillian M. Rutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant R. Charles MacLellan (Address) 3806 Bonner Road

15 Robert P. Harrison, Registrar

JUN 5 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 7, 1922, to June 3, 1922,

that I last saw her alive on June 3, 1922,

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood culture Mad

(Signed) Wilbur C. Hamilton, M. D.

June 4, 1922 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 6/6 1922

20 UNDERTAKER W. J. Gaehner & Sons — ADDRESS North Ave

CAUSE OF DEATH. See instructions on BACK OF CERTIFICATE. ATTENTION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Homer Todd
735 N. Fulton Ave
Could not find any
infection

Spec.---6-9-19---H. P. Co.---1000 Bks.

155 802 D 64908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64908

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL, (ST.:) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Whitsett Clayton

(a) RESIDENCE. No. 406 E. Innis St. ST., Salisbury N. Car. WARD. Salisbury N. Ca

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or ~~WIFE of~~) Mrs. Thomas Murphey (sister)

6 DATE OF BIRTH (month, day, and year) Oct 14 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) ( )

(c) Name of employer ( )

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER Francis D'Autel C

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Katherine Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant JOHNS HOPKINS HOSPITAL. Records (Address)

15 Filed 5-1922 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to June 4, 1922, that I last saw her alive on June 4, 1922, and that death occurred, on the date stated above, at 8:23 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis } Non
Bronchiectasis } tbc.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test.

(Signed) W. S. Thayer, M. D.

6-5, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL 6-5-22

20 UNDERTAKER H. E. Hughes & A. Wdy. ADDRESS

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64909

CERTIFICATE OF DEATH. X 137

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) Mercy Hospital WARD) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Vina Sigman

(a) RESIDENCE NO. Erbacon W. Va ST., WARD Erbacon W. Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of— Mr Newman Sigman

6 DATE OF BIRTH (month, day, and year) Nov. 29 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Jesse Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Mary Whitsell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Virginia

14 Informant (Address) Mercy Hospital Records

15 Filed ....., 19..... Registrar

5-1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to June 5, 1922, that I last saw h[illegible] alive on June 5, 1922, and that death occurred, on the date stated above, at 1.35 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cyst of Left Ovary.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 1, 22

Was there an autopsy? No

What test confirmed diagnosis? Findings + physical signs

(Signed) John [illegible], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Erbacon W. Va.

DATE OF BURIAL: 6/5 1922

ADDRESS 2016 Orleans St

20 UNDERTAKER: Philip Herwig

CAUSE OF DEATH. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D 64910

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4114 Groveland Avenue ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Rothrock

(a) RESIDENCE. NO. 4114 Groveland Avenue ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Ann Staylor

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Rothrock

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Agnew

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant: Pierce J. Flanigan
(Address) 4114 Groveland Avenue

15 Filed JUN 6 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 3, 1922, that I last saw h... alive on June 3, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Senile infirmities of age.

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? ...

(Signed) H. T. Hardesty, M. D.

, 19 (Address) 1106 E. Lexington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6/6, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

TION is very important. See instructions on

D 64911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186-003 D 64911

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. E. Hildebrandt

(Residence in Baltimore: No. 1000 Mc Culloh Street St.; 64 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Dec (Month) 21 (Day) 185 (Year)

7-AGE. 64 yrs. 5 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) Keigan & Co.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, C. H. Hildebrandt

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Anna Haupt

13-BIRTHPLACE OF MOTHER, (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Hildebrandt

(Address) 1000 Mc Culloh

15- Filed JUN 6 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 3 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accidental)

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 6, 1922 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, June 6th 1922

20-UNDERTAKER, William Cook

ADDRESS 502 E. North Ave

Dr Hennessy 2802 Edmondson

is very important. See instructions on

D 64912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64912

CERTIFICATE OF DEATH.

188-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. U. P. I Infirmary 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon E Robinson

(Residence in Baltimore: No. Greenspring Ave Near Oak Road St.; yrs. 5 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. July (Month) 6 (Day) 1916 (Year)

7-AGE. 5 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Howard Co Md

PARENTS.

10-NAME OF FATHER. Laurence Robinson

11-BIRTHPLACE OF FATHER. (State or Country) Howard Co

12-MAIDEN NAME OF MOTHER. Louise Latlip

13-BIRTHPLACE OF MOTHER. (State or Country). Howard Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence Robinson

(Address) Greenspring Near Oak

15- Filed JUN 6 - 1922 Pinkeo ROBERT R. KNAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 4 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Streetcar accident, crushing injury to right leg.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 5 1922 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Clarksville Md

DATE OF BURIAL, 6/7 1922

20-UNDERTAKER. William Cook

ADDRESS 502 E North Ave

Is very important. See instructions on back.

Dr Hennessy 2802 Eastern

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64913

CERTIFICATE OF DEATH.

74-001 D 64913

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 Gilmor Ave ST., 9 WARD)

2-FULL NAME Alice C. Lethbridge

(a) RESIDENCE NO. 645 Gilmor Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert B. Lethbridge

6 DATE OF BIRTH (month, day, and year) Dec. 30 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn

PARENTS

10 NAME OF FATHER Sylus Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Mary R. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Howard C. Lethbridge (Address) 320 Cresheim Rd

15 Filed JUN 8 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11th, 1922, to June 4th, 1922, that I last saw her alive on June 4th, 1922, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos 30 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Howard C. Lethbridge M. D.

6/4, 1922 (Address) 320 E Cresheim Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Alverno

DATE OF BURIAL June 7 1922

20 UNDERTAKER H. Cook

ADDRESS H & M Co.

IMPORTANT. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64914

CERTIFICATE OF DEATH.

100-001 D 64914

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1057 N Durham ST.; 7 WARD)

2-FULL NAME Albert Junius McClaren

(a) RESIDENCE. NO. 1057 N Durham st ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Boy

4 COLOR OR RACE: colrd

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 8 1922

7 AGE — Years: — Months: 3 month Days: 4

If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Child do

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: James Albert Mc Claren

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Bertha Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N Carolina

14 Informant: James McClaren (Address) 1057 N Durham St

15 JUN 6 - 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3 1922, to June 4th 1922, that I last saw him alive on June 4 1922, and that death occurred, on the date stated above, at 4 o'clock a. m.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

(duration) yrs. — mos. 3, ds.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thomas J Timms, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: June 6 1922

20 UNDERTAKER: Wm Robert A Gleitz — ADDRESS: 1725 Ashland Av

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchus Pneumonia - 2 days

No other infection

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 64915

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2038 Walbrook ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie M. Carroll

(a) RESIDENCE. NO. 2038 Walbrook ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James J Carroll

6 DATE OF BIRTH (month, day, and year) aug 10/1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Webbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Margaret Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo Carroll
(Address) 2038 Walbrook Ave

15 Filed JUN 6 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to June 4, 1922, that I last saw h.. alive on June 3, 1922, and that death occurred, on the date stated above, at 9.40 Am m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred C Jewett, M. D.

19 (Address) 2516 Penn. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park	June 7 1922

20 UNDERTAKER Fosnich & Son ADDRESS 1600 W North ave

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Neebe.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64916

CERTIFICATE OF DEATH.

15 - 90

D 64916 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara M. Neebe

(a) RESIDENCE. NO. 2609 Keyworth Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Neebe

6 DATE OF BIRTH (month, day, and year) Jan 13, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia Pa
(State or country)

PARENTS

10 NAME OF FATHER Carl Simrod.

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Henry J. Neebe
(Address) 2609 Keyworth Ave

15 Filed JUN 6 - 1922 19 ROBERT R. KRAMER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to June 4, 1922, that I last saw h[illegible] alive on June 4, 1922, and that death occurred, on the date stated above, at 11:45 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Illness

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. C. Wiesz, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 7 1922
20 UNDERTAKER	ADDRESS
Josiah Lefler	1600 N North Ave

CAUSE OF DEATH. See instructions on back of certificate.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64917

CERTIFICATE OF DEATH.

129 D 64917

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Warner ST., 21 WARD)

2-FULL NAME Mary Tolson

(a) RESIDENCE NO. 628 Warner ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: George Tolson

6 DATE OF BIRTH (month, day, and year): ——— 1863

7 AGE: Years 59 | Months — | Days — | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work 037

(b) General nature of industry, business, or establishment in which employed (or employer): work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Berry Ringgold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louisa Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Annie Davis
(Address): Atlantic City N.J.

15 Filed JUN 6 1922 ROBERT R. KNAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June, 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec, 5, 1920, to June, 4, 1922, that I last saw h[illegible] alive on June, 4, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Chronic Interstitial nephritis, Uraemia

(duration) yrs. mos

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Uremia, blood pressure

(Signed) Wm Franklin M. D.

6/5, 1922 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL 6/6/22

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 1114 W Lanvale

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64918

REGISTERED NO. 26 7-100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willbur Jenkins

(a) RESIDENCE. No. Folleys, Anne Arundel Co., Md. WARD. Anne Arundel Co. Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. / ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 2 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Howard Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co. Md

12 MAIDEN NAME OF MOTHER Rosa Goodrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Md

14 Informant Howard Jenkins (Address) Folleys Md

15 Filed JUN 6 - 1922 J. H. Mehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 4, 1922, that I last saw him alive on June 4, 1922, and that death occurred, on the date stated above, at 12:00 P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wilbur Jenkins M. D.

6/5/22 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	June 6 1922
20 UNDERTAKER John P. Denny	ADDRESS 715 Light St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64919

100-001

D 64919

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3128 Guilford ave ST.; 12 WARD)

2-FULL NAME Beatrice A. Evans

(a) RESIDENCE. No. 3128 Guilford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 20 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo T. Evans

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary E. Sheridan

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto

14 Informant Geo T. Evans
(Address) 3128 Guilford ave

15 Filed . 19 JUN 6 - 1922

ROBERT A. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1922, to June 3, 1922

that I last saw h[illegible] alive on June 3, 1922

and that death occurred, on the date stated above, at 10, .m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) ow

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert F. Green M. D.

6.5. 1922 (Address) 120 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/6/22

20 UNDERTAKER Chas S. Evans & Son ADDRESS 118 W. Mt Royal ave

TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Spec.--6-9-19—H. P. Co.—1000 Bks.

15533 D 64920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 129 D 64920

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Baggle

(a) RESIDENCE. NO. Ellicott City, Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced (write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) May 27-1922

7 AGE: Years 52 Months 9 Days

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Baggle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed JUN 6 - 1922 ROBERT N. KRAMER, Registrar

Burial Permit Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to May 27, 1922

that I last saw him alive on May 27, 1922

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood chemistry.

(Signed) C. Sidney Burwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JUN 5 1922

TION is very important. See instructions on back of

Permit held by

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64921

CERTIFICATE OF DEATH.

74-001

D 64921

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3051 Stricker ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland A Scott

(a) RESIDENCE NO. 3051 N Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Scott

6 DATE OF BIRTH (month, day, and year) Oct 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	69	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Augustus Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Scott (Address) 306 N Stricker St

15 Filed JUN 6 - 1922 ROBERT N. KNIGHTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to June 4, 1922, that I last saw him alive on June 0, 1922, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

(Duration) yrs. 2 mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C N Hoover M. D.

June 5, 1922 (Address) 7128 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL June 7th 1922

20 UNDERTAKER Harmon & Wright ADDRESS 1619 Mc Cay

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64922 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 64922 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 917 W. Lexington ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Lorenz

(a) RESIDENCE NO. 917 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Lorenz

6 DATE OF BIRTH (month, day, and year): May 1 1857

7 AGE — Years: 65 — Months: 1 — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ignatius Lorenz

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Mrs Lena Lorenz (Address) 917 W Lexington St

15 Filed JUN 6 - 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/3/22 19

17

I HEREBY CERTIFY, That I attended deceased from 5/27/22, 19 ..., to 6/3/22, 19 ...,

that I last saw him alive on 6/3/22, 19 ...,

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) Many yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible] M. D.

6, 19 22 (Address) 916 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 6/7 1922

20 UNDERTAKER: George A Farley Fulton & Laycock — ADDRESS

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64923

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Nasoski

(a) RESIDENCE. No. 1608 Fleet St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed JUN 6 - 1922 H. Wahn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922 to June 5, 1922

that I last saw him alive on June 5, 1922

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Carroll M. D.

6/6/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 6 1922

20 UNDERTAKER: Johnson & Weber ADDRESS: 1803 Bank

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64924

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH Mt Royal Ave & Calvert St

CITY OF BALTIMORE: (No. Mt Royal Apartment ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Ensor

(a) RESIDENCE NO. Mt Royal Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie J. Ensor

6 DATE OF BIRTH (month, day, and year) Mch 25. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer 045

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. Md (State or country)

PARENTS

10 NAME OF FATHER Thomas E Ensor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary F. Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie J. Ensor

(Address) Mt Royal apartment

15 Filed 6-1922, 19 Robert T. [illegible] Registrar

Burial Permit Clerk

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to June 5, 1922, that I last saw him alive on June 4, 1922, and that death occurred, on the date stated above, at 640 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma stomach

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Gland enoimed.

(Signed) John O. Mitchell, M. D.

, 19 (Address) 730 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL June 7 1922

20 UNDERTAKER John O. Mitchell

ADDRESS 1201 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

(Teleofor Gnatowski) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64925

CERTIFICATE OF DEATH.

D 64925

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1628 Thames ST., 15 WARD)

2-FULL NAME Teleofor. Gnatowski

(a) RESIDENCE NO. 1628 Thames ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - - - - - -

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 46	6	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. O40
(b) General nature of industry, business, or establishment in which employed (or employer) Packing House.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph. Gnatowski
11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.
12 MAIDEN NAME OF MOTHER Rogumska
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Antony. Gnatowski
(Address) 1628 Thames St.

15 Filed 6-1922 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/4 1922 to 6/5 1922.
that I last saw h. alive on 6/5 1922.
and that death occurred, on the date stated above, at 2 45 A m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) Dr. A Andrade M. D.
6/5 1922 (Address) 1823 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL June 7 1922

20 UNDERTAKER William Fiaschowski ADDRESS 1618 Eastern

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64926

CERTIFICATE OF DEATH.

D 64926

1-PLACE OF DEATH

REGISTERED NO. 6 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1724 Mulliken St.; 6 WARD)

2-FULL NAME Annie Green Wilson

(a) RESIDENCE. No. 1724 Mulliken St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of John H. Wilson

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ~~07~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Benj. Abney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nettie Horsey daughter
(Address) 1724 Mulliken St

15 Filed . 19 Robert P. Harrison, Registrar

8-1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1922 to 6/4, 1922, that I last saw h. W. alive on 6/4, 1922, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Parenchymatous nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arthemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab

(Signed) R. J. Young, M. D.

. 19 (Address) 1424 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cem	June 7 1922
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks	1308 Jeffers

TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

15-D 64927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64927

CERTIFICATE OF DEATH. X 44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (WARD) 7

2-FULL NAME Ray Duckworth

(a) RESIDENCE NO. Canton, N.C. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	1	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Jas J Duckworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canton N.C

12 MAIDEN NAME OF MOTHER Lillie Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) NC

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed JUN 8 1922 19 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1 1922, to June 5 1922, that I last saw him alive on June 5th 1922, and that death occurred, on the date stated above, at 8-15 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver

(duration) 0 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Carolina

Did an operation precede death? Yes Date of June 5. 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Klemmerson, M. D.

6, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Canton N C. DATE OF BURIAL June 6 1922

20 UNDERTAKER Joseph Ahrens ADDRESS 22 E Mt

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

N 8 - 1922

Spec.—1-10-21—M&T—1500 blks.

D 64928 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64928

48

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4150 Falls Road (St.) 13 (WARD)

2-FULL NAME Estridge J. Perry

(a) RESIDENCE NO. 4150 Falls Road St., WARD 13
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: the late Rapp W Perry

6 DATE OF BIRTH (month, day, and year): Feb 17 18 [illegible]

7 AGE: Years 76; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Ann Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Estridge J. Perry
(Address) 4150 Falls Road

15 Filed ..... 19 ..... Registrar
Robert F. Harrison,
Burial Permit Clerk

R — 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. , 1921, to June 6 , 1922,
that I last saw her alive on June 6, , 1922,
and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Rodent Ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. H. Machen, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: June 8 1922

20 UNDERTAKER: Robt F. Tennis

ADDRESS: 1 X X 2 W. Baltimore

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

156339
D 64929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E. Bragg.

(a) RESIDENCE. NO. Grafton W. Va ST., R. F. D. #2. WARD. Grafton W. Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of Sarah Bragg (wife)

6 DATE OF BIRTH (month, day, and year) May 2, 1854.

7 AGE: Years 67 Months 1 Days 4 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Edward L. Bragg

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Billie Clendening

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed ....., 19 ..... Registrar

Robert P. Jeffries Clerk.

8 1922 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 6, 1922, that I last saw him alive on June 6, 1922, and that death occurred, on the date stated above, at 5 40 a. m.

The CAUSE OF DEATH* was as follows:

Hematuria, Cause undetermined

(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Franklin P. Johnson, M. D.

19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Grafton W. Va — DATE OF BURIAL: 6/6/22

20 UNDERTAKER: Chas. A. Evans & Son — ADDRESS: 118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificate.

D 64930 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64930

CERTIFICATE OF DEATH. Registered No. C 170

1-PLACE OF DEATH

City of BALTIMORE: (No. 1847 W Pratt St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Otto Becker

(Residence in Baltimore: No. 1847 W Pratt St.; yrs. 38 mos. 8 ds. 17)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept. (Month) 19 (Day) 1884 (Year)

7-AGE. 38 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Ed A Becker

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Anthine Lentz

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman E Becker

(Address) 1847 W. Pratt St.

15- Filed JUN 8 1922 192.. Robert F. Harrison, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound - Brain
Self inflicted Suicide
(Duration) 0 yrs. mos. ds. Sudden

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) James H. Fenton M. D.
(Coroner.)
6/6 1922 (Address) Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL June 8th 1922

20-UNDERTAKER, E. B. Hoffman ADDRESS 2236 Eutaw

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64931

CERTIFICATE OF DEATH.

90 D 64931

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 713 S. Fremont St. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alexander Jones

(Residence in Baltimore: No. 713 S. Fremont St. St., 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... (Month) dont know (Day) 1 (Year) .....

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Alex Jones

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER dont know

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Jones

(Address) 713 Fremont St

15- Robert P. Harrison,

Filed ..... 191 ..... Clerk.

Registrar.

CAUSE OF DEATH in plain terms, and important. See instructions on back of certificate.

B - 1977 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 4 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

June 5, 1922 (Address) 117 N. Gaulay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, June 7, 1922

20-UNDERTAKER Edward Ruggold

ADDRESS 1463 Carey St

D 64932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64932

CERTIFICATE OF DEATH.

185

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Clare Shops B&O RR St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Cornelius Cook

(Residence in Baltimore: No. 1416 Mosher St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): B&O R.R.

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER, Cook

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lonnie Rayland

(Address) 1416 Mosher St

15-

Robert F. Harrison,

1922 ..... 192 ..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture artery base of brain due to fall striking his head against floor of Flat Car accident (Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver (Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

June 4 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon DATE OF BURIAL, June 7 1922

20-UNDERTAKER, Sam H Black Inc ADDRESS 1400 Mosher

1922

Please write plainly. See instructions on back of certificate. This is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64933

CERTIFICATE OF DEATH.

47 D 64933

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 N. Dunbar St ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R. Cooper

(a) RESIDENCE. NO. 1011 N. Dunbar St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Charles H Cooper

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launderess

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) U. S. A. Maryland St. Mary's Co.

PARENTS

10 NAME OF FATHER Jas. Travers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Milburne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucy Fenwick (Address) 1011 N. Dunbar St

15 Filed Nov 19 — Robert P. Harrison, Registrar

6-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to June 6, 1922

that I last saw h.. alive on June 8, 1922

and that death occurred, on the date stated above, at 955 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Breast
metastasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Mary Lindsay, M. D.

6-6 1922 (Address) 141 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cath Cemetery - St Mary's Co	June 7 1922
20 UNDERTAKER Sam'l H Brace Son	ADDRESS 1108 McC

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

D 64934 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64934

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 13 188-00 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hall Parsley

(Residence in Baltimore: No. 2006 Gerald ave. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W.	Sgl

6-DATE OF BIRTH, April 7 (Month) (Day), 1894 (Year)

7-AGE 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jno Parsley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margt. Day

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Day

(Address)

15-

Filed ..... 191..... Registrar.

ROBERT P. HARRISON,

6-1922 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it can be understood. Be sure to fill out all items. All are important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Traumatic amputation both legs;
Shock 1 by Struck by R.R. Engine
accidental (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

June 6, 1922 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Grant MD

DATE OF BURIAL, June 7, 22

20-UNDERTAKER Commonwealth Undertaking Co

ADDRESS

D 64935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64935

CERTIFICATE OF DEATH.

REGISTERED No. C 5179

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 406 Ensor ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Muffoletto

(Residence in Baltimore: No. 406 Ensor St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 2 yrs. 3 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... nn. child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Salvatore Muffoletto

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER C. Caliotta

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Muffoletto

(Address) 406 Ensor St

15- June 6, 1922 Robert P. Harrison, Burial Permit Clerk.

Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 4 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns - accidental
walked on hot tar
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

June 6, 1922 (Address) ..... 1629 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery

DATE OF BURIAL, 6/6/22 19....

20-UNDERTAKER George J Ruth

ADDRESS 1735 Harford Av

Spec.—1-10-21—M&T—1500 Bks.

D 64936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Inf. 6 161-001 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Chalk

(a) RESIDENCE No. Aberdeen ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 6 1922

7 AGE — Years — Months — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Ed A Chalk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Maryland

12 MAIDEN NAME OF MOTHER: Bertie Galion

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Maryland

14 Informant: Ed A Chalk
(Address) Aberdeen Md

15 Filed ....., 19..... ROBERT P. PATTISON, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922 to June 6, 1922

that I last saw her alive on June 6, 1922

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. 4 hrs. ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? (!)

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Gaetano Panettieri M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md — DATE OF BURIAL: 6/6 1922

20 UNDERTAKER: A G Hughes — ADDRESS: 434 N. Broadway

CAUSE OF DEATH must be filled in. See instructions on back of certificates.

A - 1919

Spec.—1-10-21—M&T—1500 Bks.

D 64937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1559387

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Reese

(a) RESIDENCE NO. 1004 S. Main St ST., WARD Anderson S. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Jan 27 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER William Neil

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed Nov 8 -- 1922, 19.. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922 to June 6, 1922, that I last saw h[er] alive on June 6, 1922, and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall-bladder + ducts

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) General carcinomatosis, Cachexia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Feb. 15, 1922 May 22, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + Autopsy

(Signed) W M Zinninger M. D.

June 6 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Anderson S. C.

DATE OF BURIAL Nov 8 1922

20 UNDERTAKER H E Hughes

ADDRESS Anderson S C

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64938

CERTIFICATE OF DEATH.

D 64938

REGISTERED NO. 3/D 64938

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 17 (WARD)

2-FULL NAME Robert Thompson

(a) RESIDENCE. NO. 917 Argyle ave. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dishwasher

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Arthur Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address) M. T. H.

15 Filed JUN 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to June 3, 1922, that I last saw him alive on June 3, 1922, and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pnaumothorax (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) Frances L. Padaglucca M. D.

6-3-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Jun 7 1922

20 UNDERTAKER Daniel Easton

ADDRESS 916 Paca

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 64939

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Vincent ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Wilson

(a) RESIDENCE NO. 518 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Wilson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic service

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Herbert Wilson

(Address) 518 Vincent St

15 Filed JUN 7 - 1922 19 ROBERT N. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to June 5, 1922.

that I last saw h ve alive on June 4, 1922,

and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Knapp M. D.

(Address) 1900 Linden Ave

6/5/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 8 1922
20 UNDERTAKER Daniel Carbin	ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64940

CERTIFICATE OF DEATH.

1780 D 64940

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 W Biddle St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence C. Cooper

(Residence in Baltimore: No. 518 W Biddle St. St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 25 1887 (Month) (Day) (Year)

7-AGE, 35 yrs. 10 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Peters Cooper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Burris

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliza Cooper

(Address) 518 W Biddle St

15- Filed JUN 7 - 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4th, 1922. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd 1922, to June 4th 1922, that I saw him alive on June 4th 1922, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Edema of Lungs

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

June 5th, 1922 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, June 7 1922

20-UNDERTAKER Samuel I Hemsley ADDRESS 578 N Biddle St

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 64941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64941

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 657 Bradley ST., 17 WARD)

2-FULL NAME Estelle. Baker

(a) RESIDENCE NO. 657 Bradley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 9/12/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) 657 Bradley, Balto Md

PARENTS

10 NAME OF FATHER Wm H. Burrows

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Palmer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wm H. Burrows
(Address) 657 Bradley Ave

15 Filed JUN 7 - 1922 ROBERT N. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/1922

17 I HEREBY CERTIFY, That I attended deceased from 6/2/8, 1922 to 6/6, 1922

that I last saw h alive on 6/6, 1922

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bronchs-pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

6/6, 1922 (Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL June 8 1922

20 UNDERTAKER Bowley & Budde ADDRESS 528

CAUSE OF DEATH in plain terms, so that it may be of use in compiling statistics. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64942

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 64942

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital. ST., 17 WARD)

2-FULL NAME James Davenport

(a) RESIDENCE NO. 537 Walnut St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Anthony Davenport

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ceclia Pree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records. (Address) Municipal Hospital.

15 Filed JUN 7 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 19 22

17 I HEREBY CERTIFY, That I attended deceased from February 24 19 22 to June 4 19 22.

that I last saw him alive on June 4. 19 22.

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of esophagus

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary anemia, Unknown
Hypostatic pneumonia 3das
(duration) yrs. mos ds.
Cancer Cachexia Unknown.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Feb 10-22

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Exam.

(Signed) J. S. Hines, M. D.

6/7 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lit Cemetery DATE OF BURIAL June 8 1922

20 UNDERTAKER Samuel D. Hensley ADDRESS 328 N. Bradford

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64943

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 64943

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH Robt Garrett Hosp for Children

CITY OF BALTIMORE: (No. 27 N Carey ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Glaeser

(a) RESIDENCE NO. 1334 James ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 weeks ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3wks	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ppl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Glaeser

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York City

12 MAIDEN NAME OF MOTHER Isabella Fuchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John H. Glaeser

(Address) 1334 James St

15 Filed JUN 7 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1922 to June 6, 1922.

that I last saw him alive on June 5, 1922

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Prematurity & Patent Foramen Ovale / Buhs

(duration) yrs. / mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. W. F. Clift, M. D.

6/6, 1922 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL June 7 1922

20 UNDERTAKER John F. Cowan & Co

ADDRESS 1 Holliday St

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64944

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 64944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Gough St.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Lowensen

(a) RESIDENCE. NO. 1921 Gough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Elizabeth Lowensen

6 DATE OF BIRTH (month, day, and year): May 24, 1842

7 AGE: Years: 80 Months: Days: 10 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder & Contractor

(b) General nature of industry, business, or establishment in whirh employed (or employer): 116

(c) Name of employer

9 BIRTHPLACE (rity or town) (State or country): Luden Hannover Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (rity or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (rity or town) (State or country): Germany

14 Informant: Mrs Lowensen (Address) 1921 Gough.

15 Filed JUN 7-1922 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1919, to June 3, 1922, that I last saw h[illegible] alive on June 3, 1922, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - (cerebral)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test ronfirmed diagnosis?

(Signed) Louis A. M. Krause, M. D.

, 19 (Address) 2500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arcidental, Suirdal, or Homiridal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem

DATE OF BURIAL: June 7 1922

20 UNDERTAKER: J Ellicott

ADDRESS 2008 Aisquith

CAUSE OF DEATH must be plainly written, and answers on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64945

CERTIFICATE OF DEATH.

90D 64945

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew Hosp ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Brown

(a) RESIDENCE. NO. 1037 N. Front ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 28; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Ethel Gorgas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Levis 1439 E Balto St

15 Filed JUN 7 - 1922, 19.....

ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1922

17

I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 6, 1922

that I last saw h alive on June 6, 1922,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis, Cardiac Arrhythmia (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Zinberg, M. D.

6/6, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle

DATE OF BURIAL: 6/9th 1922

20 UNDERTAKER: Jack Levis 1439 E Balto St

ADDRESS

CAUSE OF DEATH must be given. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64946

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

44 D 64946

Registered No. C.....

City of BALTIMORE: (No. 734 N. Wolfe St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Peter J Paulus

(Residence in Baltimore: No. 734 N. Wolfe St St.; yrs., 52 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced (Write the word.) Married

6-DATE OF BIRTH. January 15th, 1869
(Month) (Day) (Year)

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Wholesale Liquor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Jacob Paulus

11-BIRTHPLACE OF FATHER, (State or Country). Penna

12-MAIDEN NAME OF MOTHER. Margaret Stuart

13-BIRTHPLACE OF MOTHER, (State or Country). Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Paulus

(Address) 107 N. Chapel

15-

Filed JUN 7 - 1922 ROBERT R. KNAUER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Pollitt M. D.
(Coroner.)

June 7 1922 (Address) 502 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, June 8, 1922

20-UNDERTAKER, William Cook — ADDRESS 502 E North Ave

Is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

a Sr. Nurse N. Cry.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D 64947

CERTIFICATE OF DEATH.

D 64947

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Rutland Cr ST., 8 WARD)

2-FULL NAME Walter J. Meyers

(a) RESIDENCE NO. 1623 Rutland Cr ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— none

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Walter Meyers

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mabel Stallings

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Walter Meyers
(Address) 1623 Rutland Ave

15 Filed JUN 7 - 1922, 19 ... ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1922, to June 6th 1922, that I last saw him alive on June 5th, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Life

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) Life yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard Woodruff M. D.

6/6, 1922 (Address) 730 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Redeemer — DATE OF BURIAL 6/7 22

20 UNDERTAKER Wm Cook — ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

(See Letter attached)

D 64948

HEALTH DEPARTMENT—CITY OF BALTIMORE

N 64948

X 182

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 3 Canton ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elfy Edwin Roberts

(Residence in Baltimore: No. Steamship (Cornish City) St.; yrs., mos., ds.) Since June 1st 1922

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1905.
(Month) (Day) (Year)

7-AGE, 17 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Apprentice Sailor
(b) General nature of industry, business, or establishment in which employed (or employer): D 86

9-BIRTHPLACE, (State or Country) Borth, Cardiganshire South Wales,

PARENTS.

10-NAME OF FATHER, John E. Roberts

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas W. Bowen

(Address) 15 Roath Court Place Cardiff England

15- JUN 7 - 1922 ROBERT R. KRAUTER, Registrar.
Filed ..... 191.....
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, found June 4th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. ..... 2. .....
accidental Drowning
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) In swimming

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. W. Norton M. D.
(Coroner)

June 4th, 1922 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths FROM VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, June 7th, 1922

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

AGENTS
ED STATES NAVIGATION CO., INC.
GENERAL AGENTS
REARDON-SMITH LINE, LTD.

BALTIMORE TO LIVERPOOL,
LONDON AND HAMBURG

MAURICE B. CARLIN & COMPANY

STEAMSHIP AGENTS-SHIP BROKERS

ABELL BUILDING

BALTIMORE

CABLE ADDRESS: NILRAC

CODES:
SCOTT'S 10TH EDITION
A. B. C. 6TH EDITION
BENTLEY'S IMPROVED

TELEPHONES:
PLAZA 2823-2824-2825

June 17th, 1922.

Dr. Thomas B. Horton, Coroner,
Cedar & Curtis Aves.,
Curtis Bay, Md.

Dear Sir:- s/s"Cornish City"

The following is copy of letter sent you June 12th, which you advused had not been received.

"We refer to one Elfy Edwin Roberts, Apprentice on board Br. s/s"Cornish City", who was drowned while bathing at Pier # 3 Canton, body found June 4th.

In issuing Certificate of Death, the birthplace of the deceased was given as Bideford, England, which is incorrect. Roberts was born in Borth, Cardiganshire, South Wales, and we are informed by the Health Department that in order to change the certificate it will be necessary for you to write them that an error has been made and ask them to change the records to Borth, Cardiganshire, South Wales.

This information was furnished us by the Captain of the s/s "Cornish City", for which we are the local agents, also in the presence of the British Consul, Hugh Alex. Ford, Esq.

We would thank you to communicate with the proper authorities or give us a letter which will enable us to secure a correct Certificate of Death."

Thanking you for any assistance you may give and trusting you will not be inconvenienced, we are,

Very truly yours,

MAURICE B. CARLIN & COMPANY,

Chas J Wheeler

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64949

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Holliday

(a) RESIDENCE. No. 11 S. Duncan st. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Holliday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Hospital Records (Address) M.T.H.

15 Filed JUN 7 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to June 5, 1922, that I last saw h ex alive on June 5, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglacca M. D.

6-5-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	June 7 1922
20 UNDERTAKER	ADDRESS
Wm J. Jackson	156 East-St

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64950

CERTIFICATE OF DEATH.

161 1001 D 64950

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1819 N. Spring ST., 9 WARD)

2-FULL NAME Myrtle Stewart

(a) RESIDENCE NO. 1819 N. Spring ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 1922

7 AGE — Years — Months | Days 21 | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Stewart

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Hattie Pinkett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hattie Stewart
(Address) 1819 N. Spring Ave

15 Filed JUN 7 - 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1922, to June 6, 1922

that I last saw h... alive on June 6, 1922, at 4P. m.

and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows:

Premature birth of
Premature birth of Embryo
Premature Detachment of Placenta
(duration) Unknown mos ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Schmidt M. D.

(Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem | DATE OF BURIAL June 7 1922

20 UNDERTAKER Mrs Robert A Elliott | ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly CODED. See instructions on back of certificates. This is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 64951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64951

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1047 W. Barre ST. 21 WARD)

2-FULL NAME Edith a. Weigman

(a) RESIDENCE NO. 1047 W. Barre ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May 23 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sharp + Dohme

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Charles Weigman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Mrs. Emma Weigman 1047 W. Barre St

15 Filed JUN 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921 to June 6 1922

that I last saw her alive on June 6 1922

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

Myocarditis Acute (duration) yrs. - mos. 15 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) W W Eveingen M.D.

(Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery.

DATE OF BURIAL June 8 1922

20 UNDERTAKER James Di'guan + Son

ADDRESS 1000 S. Paca St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64952

CERTIFICATE OF DEATH.

90

D 64952

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew aged Home ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Sapperstein

(a) RESIDENCE No. 115 ais Smith Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of David Sapperstein

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris B. Kleiman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1437 E Baltimore St

15 Filed JUN 7 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 6, 1922, that I last saw her alive on June 6, 1922, 7:30 P. m. and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Boylin, M. D.

6/7, 1922 (Address) 210 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Sanitarium Cem

DATE OF BURIAL 6/7 1922

20 UNDERTAKER Jack Lewis 1437 E Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 64953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Light St. 22 WARD)

2-FULL NAME Michael Dundon

(a) RESIDENCE NO. 803 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: E Dundon

6 DATE OF BIRTH (month, day, and year): Dec 18 1829

7 AGE: Years 92 | Months 5 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Mfgr. 817

(b) General nature of industry, business, or establishment in which employed (or employer): at 803 Light st

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Trenton New Jersey

PARENTS

10 NAME OF FATHER: John Dundon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Irland

14 Informant: John J Dundon

(Address): 803 Light st

15 Filed JUN 7 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 18, 1922, to June 5, 1922, that I last saw h in alive on June 5, 1922, and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

June 6, 1922 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 8 1922

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 64954

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 D 64954

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) 20 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reginia Rockel

(a) RESIDENCE. No. 445 Brunswick st. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Rockel

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER David Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Susie Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Hospital Records M.T.H.

15 Filed JUN 7 - 1922 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to June 5, 1922, that I last saw her alive on June 5, 1922, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and enteritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in Sputum, X-ray

(Signed) Frances L. Dalrymple, M. D.

6-6-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 9 1922

20 UNDERTAKER L. W. Dill — ADDRESS 3109 Frederick Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64955 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64955

31

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S. Veterans' Hospital #56

CITY OF BALTIMORE: (NO. Fort. McHenry Md. ST., 7 WARD)

2-FULL NAME Augustus Skirman

(a) RESIDENCE NO. 969 N. Bond St. Baltimore ST., Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster. 04
(b) General nature of industry, business, or establishment in which employed (or employer) --
(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital records.
(Address) Fort McHenry Md.

15 JUN 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1922, to June 5, 1922, that I last saw him alive on June 5, 1922, and that death occurred, on the date stated above, at 9. p.m.

The CAUSE OF DEATH* was as follows:
Chr. Pulmonary Tuberculosis advanced & active.

Unknown -- (duration) -- yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary) ----
(duration) -- yrs. -- mos. - ds.

18 Where was disease contracted if not at place of death? Unknown.
Did an operation precede death? no Date of --
Was there an autopsy? No
What test confirmed diagnosis? Sputum & Exam. report.

(Signed) H.D Luce M. D.
Surgeon (R) U.S.P.H.S.
6/5/. 1922 (Address) U.S. V. Hosp. #56 Fort McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cem	June 8 1922
20 UNDERTAKER	ADDRESS
F.A. Krause & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter attached)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64956

D 64956

CERTIFICATE OF DEATH.

117

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital ST. 2[illegible] WARD) (formerly Rehau) (2078 W. Fayette St)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Sterget.

(a) RESIDENCE NO. 221 S. Jas at ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9 - 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Attended

(b) General nature of industry, business, or establishment in which employed (or employer) School.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph G. Sterget.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna M Hammerbacher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Joseph G. Sterget. 207 S. Jas St

Robert [illegible]

15 Filed 19 Burial Permit Clerk. Registrar

7-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 6, 1922, that I last saw h[illegible] alive on June 6, 1922, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

(Myocardial insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured appendix and general peritonitis (duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of June 5, 1922.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Harold C. Pillsbury, M. D.

, 19 (Address) 415 Cedarcroft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL June 9 1922

20 UNDERTAKER Lilly & Zeile

ADDRESS 403 S. W St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

ST. JOSEPH'S HOSPITAL
CAROLINE & OLIVER STS.

BALTIMORE, MD., June 8, 1922.

Dr. C. Hampson Jones.

Dear doctor -

I have seen the papers of adoption of Catherine Behan to Mr. + Mrs. Thergett and do here by certify that Catherine Behan and Catherine Thergett are one and the same person.

Harold C. Pillsbury M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64957

CERTIFICATE OF DEATH.

101 091 D 64957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3916 E. Pratt ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Collins

(a) RESIDENCE NO. 3916 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna E. Collins

6 DATE OF BIRTH (month, day, and year): Aug. 16-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Crane Operator 086

(b) General nature of industry, business, or establishment in which employed (or employer): Sp. Pt. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Anna E. Collins

(Address): 3916 E. Pratt St.

15 6-7-1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to June 6, 1922

that I last saw alive on June 5, 1922

and that death occurred, on the date stated above, at 4.35 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. D. Neer, M. D.

6/6/22 (Address) 408 S Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. St. Stanislaus Cem.

DATE OF BURIAL: June 9th 1922

20 UNDERTAKER: Lilly & Zeiler.

ADDRESS: 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 64958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64958

CERTIFICATE OF DEATH.

139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hettie Reigale

(a) RESIDENCE. NO. 5535 Roland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE: Years 72; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milliner 086

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER John Reigale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER Emma Weiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Hospital Records.

15 Filed Jun 7, 19 22 Registrar

Burial Permit Clerk.

JN 7-1922

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 6, 1922, that I last saw her alive on June 6, 1922, and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Myoma

6 wks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

8 hrs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 3-1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) S. E. Broadus M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hanover Pa. DATE OF BURIAL: June 8 22

20 UNDERTAKER: A S Marshall ADDRESS: 3539 Fallsd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfuiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64959

CERTIFICATE OF DEATH.

161 - 802 D 64959

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bankins.

(a) RESIDENCE NO. 1101 N. Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ddd

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Bankins.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Edna Herbert.

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Md

14 Informant .....
(Address) .....

15 ..... , 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17

I HEREBY CERTIFY, That I attended deceased from 6-6, 1922 to 6-6, 1923

that I last saw her alive on 6-6, 1922,

and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Prematurity - 6 mo.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Susanne R Parsons, M. D.

6-6, 1922 (Address) 1702 Westwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL JUN 1922

20 UNDERTAKER .....

ADDRESS .....

Robert T. Harrison,
Commissioner of Health.

Burial Permit Clerk

6-7-1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease. TION is very important. See instructions on back of certificates.

D 64960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Bay View Hospital WARD)

2 FULL NAME Baby Link

(Residence in Baltimore: No. — Kirkman St

REGISTERED No. C 161 D 64960

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, May 31st, 1922
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 1 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country): Kirkman St - City

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): U.S.

12-MAIDEN NAME OF MOTHER: Bertha Link

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) Eastern Dist

15- Robert P. Harrison,
....., 191.....
Burial Permit Clerk.
Registrar.

N.C. 7-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31st, 1922
..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1 hour (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Born in trucker. Head hit bottom trucker

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

May 31 1922 (Address) Curtis Bay, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: [redacted] LIC CEMETERY.

DATE OF BURIAL, JUN 7 1922

UNDERTAKER: LIC CEMETERY.

ADDRESS

D 64961

HEALTH DEPARTMENT—CITY OF BALTIMORE

1884-93 64961

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME .....

(Residence in Baltimore: No. ..... St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE.

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH.

(Month) (Day) (Year)

7-AGE yrs. mos. ds.

If LESS than 1 day hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- JUN 7-1922 192 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. (Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

..... 192 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY.

DATE OF BURIAL. 19

20-UNDERTAKER.

ADDRESS JUN 7 1922

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is very important. See instructions on back of certificate.

D 64962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 64962

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1124 N. Port St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Sackett

(Residence in Baltimore: No. 1124 N. Port St., 20 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced: (Write the word.) Married

6-DATE OF BIRTH: unknown, 1.....
(Month) (Day) (Year)

7-AGE: 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Co, Md

PARENTS.

10-NAME OF FATHER: Wm Horsey

11-BIRTHPLACE OF FATHER, (State or Country): Easton Shore Md

12-MAIDEN NAME OF MOTHER: Annie (unknown)

13-BIRTHPLACE OF MOTHER, (State or Country): Easton Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L Richardson
(Address) 1124 N. Port St

15-

Filed ..... 192.....

Registrar.

N 7-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism (Duration) 5 yrs. mos. ds.

(Signed) J. H. Falls M. D.
(Coroner.)

June 7 192 2 (Address) 5 a. S. E. Northern

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Easterly (Cem) DATE OF BURIAL, 6/8/, 19 22

20-UNDERTAKER, Jas. W. Elkins ADDRESS 1625 E. Fayette

Robert F. Garrison, Burial Permit Clerk.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64963

CERTIFICATE OF DEATH.

D 64963

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 N. Fremont Ave ST.: 15 WARD)

2-FULL NAME Rebecca Mears

(a) RESIDENCE. No. 1330 N. Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Mears

6 DATE OF BIRTH (month, day, and year) Not known 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Scruggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ellen Scruggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Bertha Ramsey (Address) 1330 Fremont Ave.

15 Filed JUN 7 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1922, to June 6, 1922, that I last saw her alive on June 5, 1922, and that death occurred, on the date stated above, at 12.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

6/6, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 8 1922

20 UNDERTAKER James H. Dennis ADDRESS / 303 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. State whether from Disease, Violence, or Casualty. Name Disease causing Death, or in deaths from Violence state Means and Nature of Injury. DESCRIPTION is very important. See instructions on back of certificates.

Spmc.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64964

CERTIFICATE OF DEATH.

D 64964

REGISTERED NO. 114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 639 w Barre (St.) 21 (Ward)

2-FULL NAME Ida Vonheiser

(a) RESIDENCE. No. 639 w Barre St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 3 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Symon Pitkawski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Johanna Jezierski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Johanna Pitkawski
(Address) 639 W Barre St

15 Filed . 19 Registrar

Robert F. Garrison,
Burial Permit Clerk.

JN 7 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to June 6, 1922,

that I last saw h[illegible] alive on , 19 ,

and that death occurred, on the date stated above, at 7.58 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) 1 yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dorsey, M. D.

, 19 (Address) 1127 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 10 1922
20 UNDERTAKER	ADDRESS
John McNeder	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Weivera

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64965

CERTIFICATE OF DEATH.

111

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwig Weivera

(a) RESIDENCE. NO. 1815 Ashland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Jerry Weivera

6 DATE OF BIRTH (month, day, and year) March 23, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia.

PARENTS

10 NAME OF FATHER James Stalcek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Elizabeth Boziak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Jerry Weivera (Address) 1815 Ashland Ave

15 Filed [illegible] 19[illegible] [illegible] Registrar

N7 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25 1922 to June 5 1922, that I last saw h[illegible] alive on June 5 1922, and that death occurred, on the date stated above, at 6.07 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? Yes Date of June 5, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Edw. L. Wiesig, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakhill	June 8 1922
20 UNDERTAKER Fred Brockton	ADDRESS 1906 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64966

D 64966

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 S. Front ST. 3 WARD)

2-FULL NAME Mary Selvester

(a) RESIDENCE. NO. 20 S Front ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Selvester

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook Maryland Court — 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Bergmuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosalie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Selvester

(Address) 20 S Front St

15 JUN 7-1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to June 5, 1922, that I last saw h alive on June 5 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Disease

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Valentine M. D.

June 7, 1922 (Address) 42 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	June 8 1922

20 UNDERTAKER Grant Enack & Son ADDRESS 1906 Eastlake

MARRIAGE CERTIFICATE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64967

CERTIFICATE OF DEATH.

D 64967

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Louis R. Falk

(a) RESIDENCE NO. Johns Hopkins Hosp. ST., ... WARD Wheeling W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) West Virginia Martinsburg W. Va

PARENTS

10 NAME OF FATHER George M. Falk

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia Martinsburg W Va

12 MAIDEN NAME OF MOTHER Sarah Hollida

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant JOHNS HOPKINS HOSPITAL.

(Address) .....

15 Filed 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/6/ 1922, to 6/7 1922, that I last saw h[illegible] alive on 6/7 1922, and that death occurred, on the date stated above, at 8.35 p. m.

The CAUSE OF DEATH* was as follows:

cerebellar tumor

(duration) ..... yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) operation.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 6/7/22

Was there an autopsy? partial Yes.

What test confirmed diagnosis? Yes

(Signed) Grant Ward, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wheeling W. Va DATE OF BURIAL Jun 8 1922

20 UNDERTAKER Joseph absent ADDRESS 22 Bury

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64968

CERTIFICATE OF DEATH.

100-001 D 64968

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Block

(a) RESIDENCE. NO. 1606 Fairmount Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Block

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor D 88

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1429 E. Baltimore

15 Filed JUN 28 1922 HUBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/22 19

17 I HEREBY CERTIFY, That I attended deceased from 5/2/22 19 to 6/7/22 19, that I last saw h/im alive on 6/7/22 19, and that death occurred, on the date stated above, at 8.27 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Isenberg, M. D.

6/7, 19 22 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 6/8 192 2

20 UNDERTAKER Jack Lewis 1429 E Balto

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64969

CERTIFICATE OF DEATH.

90

D 64969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2236 Brookfield Ave ST., 13 WARD)

2-FULL NAME Herman L. Edlavitch

(a) RESIDENCE NO. 2236 Brookfield Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Edlavitch

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE: Years 71 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Edlavitch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Baltimore St

15 Filed JUN 8 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to June 6, 1922, that I last saw h[illegible] alive on June 6, 1922, and that death occurred, on the date stated above, at 1.a m.

The CAUSE OF DEATH* was as follows:

Disease of heart & arteries (but was active till May 29/22)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary thrombosis or embolism (duration) yrs. mos. 9½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination & symptoms

(Signed) Frank R. Smith, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehoem Herring Run — DATE OF BURIAL 6/8 1922

20 UNDERTAKER: Jack Lewis 1439 E Balt St — ADDRESS

Information should be carefully supplied. NOTE—Unless CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

191 D 64970

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. St. Joseph's Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Pleet

(Residence in Baltimore: No. 2300 Whitmore Ave St.; yrs., 24 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Unknown, (Month) (Day) 1896 (Year)

7-AGE, 26 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocery Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): D 54

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Solomon Pleet

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Nellie Kotowsky

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15-

Filed JUN 8 - 1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Carotid Cerebral Hemorrhage Result-shot wound through left temple.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Patterson M. D. (Coroner.)

June 8 1922 (Address) 508 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, 6-8, 1922

20-UNDERTAKER Jack Lewis — ADDRESS 1439 E. Baltimore St

N. B.—Every item of information should be carefully supplied. ACCURATE statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64971

CERTIFICATE OF DEATH.

64971

179

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1001 E Baltimore ST., 3 WARD)

2-FULL NAME Mary Hendelman

(a) RESIDENCE NO. 1009 E Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 65 yrs. Months: — Days: — If LESS than 1 day, ...hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Theodore Rabinowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Adelaide Rubinowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Benj Hendelman 1001 E Baltimore St

15 Filed JUN 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1922, to June 7th, 1922, that I last saw h.er alive on June 7th, 1922, and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Chronic Parenchymatous Nephritis, Chronic Myocarditis

(duration) 7 yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. A. Hutchison, M. D.

6/7 1922 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern ave

DATE OF BURIAL: June 1922

20 UNDERTAKER: Max Levinson

ADDRESS 427 E Balto St.

mation should be carefully supplied. ... Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64972

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 002

D 64972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka Lehr

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Good

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Unknown~~ (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ~~Unknown~~ (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ~~Unknown~~ (State or country) Germany

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed JUN 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to June 6, 1922, that I last saw her alive on June 6, 1922, and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis - senility

senile gangrene of left foot

decubitus ulcers of back & left hip —

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ? sepsis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & Clinical findings

(Signed) H. H. Brumbach M. D.

6/7/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 6/8 1922

20 UNDERTAKER William Cook

ADDRESS 502 E North

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64973

CERTIFICATE OF DEATH.

D 64973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 725 W Fayette ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Leary

(a) RESIDENCE NO. 725 W Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Thomas Leary

6 DATE OF BIRTH (month, day, and year): April 6, 1850

7 AGE: Years 71 Months 9 Days ..... If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Wm Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Godfrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Sarah Hamilton

(Address) 725 W Fayette St

15 Filed JUN 8 - 1922 ROBERT R. KRAUER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 6, 1922, that I last saw her alive on June 6, 1922, and that death occurred, on the date stated above, at 10 45 Am.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Paralysis)

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteri-Sclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) M. E. O'Neill, M. D.

6/7, 1922 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peter's Cemetery — DATE OF BURIAL: June 9 1922

20 UNDERTAKER: M. Doyle — ADDRESS: 15 E. Lee St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64974

CERTIFICATE OF DEATH.

16 19 22 D 64974

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 626 N. Mount St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William N. Davis

(Residence in Baltimore: No. ~~626 N. Mount St~~ 2610 Riggs ave St.; yrs. 51 mos. 11 ds. 23)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 13 (Day) 1860 (Year)

7-AGE, 51 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Thomas W. Davis

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Mary Hammond

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Davis

(Address) 626 N. Mount St.

15- Filed JUN 8 - 1922 ROBERT R. KNAUER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 5th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wounding back. (General Peritonitis)

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Homicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 5th 1922 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery. DATE OF BURIAL, June 8th 1922

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bond St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64975

CERTIFICATE OF DEATH.

1914 D 64975

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. in University Maryland Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellis D Lewis

(Residence in Baltimore: No. 3528 cottage St)

St; yrs., 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Sept (Month) 14 (Day), 1896 (Year)

7-AGE, 26 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Ft

9-BIRTHPLACE, (State or Country), Laurel Md

PARENTS.

10-NAME OF FATHER, Geo W. Lewis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ann B Risley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Lewis

(Address) 3528 Cottage St.

15-

Filed JUN 8-1922, 191.. JOS. B. KNAUER, Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6 (Day), 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(Duration) yrs. 1 mos. hours ds.

CONTRIBUTORY (Secondary) Heat & work

(Duration) yrs. 1 mos. hours ds.

(Signed) W H Grunewald M. D.
(Coroner.)

6/8, 1912. (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs..mos..ds. In the State ..yrs..mos..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltis Cemetery	6/9, 1922
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64976 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64976

CERTIFICATE OF DEATH.

REGISTERED NO. 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Wilmer alley ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine M. Savage

(a) RESIDENCE: NO. 919 Wilmer alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-27-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Savage

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Wiggs

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant Amanda Savage
(Address) 919 Wilmer (mother).

15 Filed JUN 8 - 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-7- 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-3-, 1922, to 6-7, 1922, that I last saw her alive on 6-6-, 1922, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia DW

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Wright, M. D.

, 19 (Address) 1373 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL June 8 1922

20 UNDERTAKER Mrs R. A. Elliott — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sahn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64977

43 D 64977

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Samuel Sahn~~ Daniel Sahn (white)

(a) RESIDENCE. NO. Unknown ST.. WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(mfr bricks at 2420 Orleans St.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed JUN 8 - 1922 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 4, 19 22 to June 7, 19 22

that I last saw him alive on June 6, 19 22

and that death occurred, on the date stated above, at 9:25 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: June 8 19 22

20 UNDERTAKER: John H. Denny

ADDRESS: 715 Lighter

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. SIGNATURE is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64978

CERTIFICATE OF DEATH.

3/ D 64978

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Anthony

(a) RESIDENCE. No. 1037 W. Saratoga st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Anthony

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Benjamin Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 JUN 8 - 1922 ROBERT B. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to June 5, 1922, that I last saw him alive on June 5, 1922, and that death occurred, on the date stated above, at 8.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L. Babaglucci M. D.

6-6-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 8 1922

20 UNDERTAKER Bronner Freeland & Schenck ADDRESS 114

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1853 D 64979

REGISTERED NO. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Bay View ; St.; 70 Ward)

2-FULL NAME Rudolph Gutzeit (Gutzeit)

(Residence in Baltimore: No. 1831 N. Fraimount ave St.; yrs., 35 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Widower

6-DATE OF BIRTH: Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE: about 66 yrs. ... ds.

If LESS than 1 day, ...hrs. or.....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 830

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Schlegrell

(Address) 1802 N. Wolf St

15- JUN 8 - 1922, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Left leg fractured

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton M. D.
(Coroner)

June 7th, 1922 (Address) Curtis Bay Balto. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, 6/9, 1922

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

fell down and fractured left side.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The phrase worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid housekeepers who receive a definite salary) may be entered as *Housewife, Housework*, or *At home;* and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *Bronchopneumonia* (secondary). Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc.; when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64980

CERTIFICATE OF DEATH.

123

D 64980

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gillooly

(a) RESIDENCE NO. Alms House ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Luke Gillooly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JUN 8-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 7, 1922, that I last saw h alive on June 6, 1922, and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis, Cholecystitis, Choledocholithiasis

?, (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Nephritis

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-6-22

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy + operative findings

(Signed) J. H. Bumbaugh, M. D.

6/7/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Am. DATE OF BURIAL June 9 1922

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Broadway

N.B. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64981 48 D 64981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Boyd St.; 18 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Della Webb

(Residence in Baltimore: No. 702 Boyd St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) 1 (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Della Valentine

(Address) 516 Vine St

15- Filed JUN 8 - 1922 191... ROBERT R. KRAUTER, Assistant Permit Clerk..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922, to June 6 1922, that I saw h alive on June 5 1922, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

I. Tuberculosis Meningitis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ds.

(Signed) H. H. Forwood M. D.

June 6 1922, (Address) 939 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, June 9, 1922

20-UNDERTAKER Geo. A. Holland ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64982

CERTIFICATE OF DEATH.

90 D 64982

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 202 N. Curley ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Spink

(a) RESIDENCE NO. 202 N. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Spink

6 DATE OF BIRTH (month, day, and year) Nov 11-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Charles Spink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Spink

(Address) 202 N. Curley St.

15 Filed JUN 8 - 1922 H H Weber Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/10, 1922, to 6/6, 1922, that I last saw him alive on 6/5, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J J Crane, M. D.

6/7, 1922 (Address) 2139 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	6/8, 1922
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64983

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Gough ST., 7 WARD)

2-FULL NAME Adolph Heise

(a) RESIDENCE NO. 1719 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Heise

6 DATE OF BIRTH (month, day, and year): Nov 28-1850

7 AGE: Years 71 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ludwig Heise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Lehman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Heise (Address) 1719 Gough St

15 Filed JUN 8 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1922, to June 6th, 1922, that I last saw h[illegible] alive on June 3rd, 1922, and that death occurred, on the date stated above, at 9. A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jacob L Wimer, M. D.

6-7, 1922 (Address) 30 E B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: 6/10/1922

20 UNDERTAKER: J. G. Doran ADDRESS 30 E Balto

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 64984 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64984

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 185

CITY OF BALTIMORE (No. Volenteer Hospital No. Lamston 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. Gettier

(Residence in Baltimore: No. 1502 N. Fulton Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word): Married

6-DATE OF BIRTH, Feb (Month) 26 (Day), 1861 (Year)

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter 050
(b) General nature of industry, business, or establishment in which employed (or employer):

PARENTS.

9-BIRTHPLACE, (State or Country): Balto Md

10-NAME OF FATHER, Edw P Gettier

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Mary Shipley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eliz. Gettier

(Address) 1502 N Fulton Ave

15- Filed JUN 8-1922, 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au~~ ~~topsy or~~ inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured femur due to fall while at work (Duration) yrs. a few mos. ds.

CONTRIBUTORY (Secondary) Fell from ladder (Duration) yrs. a few mos. ds.

(Signed) W. K. Gorsuch M. D. (Coroner.)

6-8, 1922 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, 6/9/22, 19...

20-UNDERTAKER ~~Fund R. Hyde~~ Mrs Chas A G Rohde ADDRESS ~~126 Mad~~ 600 N Arlington Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64985

D 64985

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 S Bonford ave ST., 1 WARD)

2-FULL NAME Mieczyslaw Rumecki

(a) RESIDENCE NO. 635 S Monford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wawrzyn Rumecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Gabrzenyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant: Mrs Rumecki (Address) 635 S Bonford ave

15 Filed JUN 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922, to June 8, 1922, that I last saw h— alive on June 8, 1922, and that death occurred, on the date stated above, at 3-30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Ileo colitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank A. Jarrye M. D.

6/8, 1922 (Address) 243 Hart Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 9 1922
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

N. B.—WRITE plainly. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64986

CERTIFICATE OF DEATH.

101-001

D 64986

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Sterling St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara McClatten

(a) RESIDENCE. NO. 628 Sterling St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greensburg Ind

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Annie Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greensburg Ind

14 Informant (Address) Husband Samuel McClatten 628 Sterling St-Balt

15 Filed ..... 19 ..... Registrar

JUN 8 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1922, to June 5, 1922, that I last saw h[illegible] alive on June 5, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) General Septicemia

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? ——

What test confirmed diagnosis? Physical Exam

(Signed) H. D. Hall, M. D.

, 19 (Address) 1126 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL June 8 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated. EXACT. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64987

CERTIFICATE OF DEATH.

160

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 Lois Lane ST.: 20 WARD)

2-FULL NAME Mabel Holly

(a) RESIDENCE. No. 29 Lois's Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles B. Holly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Evaline Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Charles H. Holly
(Address) 29 Lois Lane.

15 Filed JUN 8 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31st, 1922, to June 6th, 1922;
that I last saw h~~e~~r alive on June 6th, 1922;
and that death occurred, on the date stated above, at 3 a—m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Operation

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings only

(Signed) J. Bosswell Fargo, M. D.

, 19 (Address) 746 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	June 8 1922
20 UNDERTAKER	ADDRESS 1174
Brown & Theland & Schwarz	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital debility
Living conditions
of family bad.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 64988

REGISTERED NO. 49

1-PLACE OF DEATH Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Frank Howard

(a) RESIDENCE. NO. Chestertown Md ST., WARD. Chestertown Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? 66 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Frank Howard

6 DATE OF BIRTH (month, day, and year) About 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer Self Chestertown Md

9 BIRTHPLACE (city or town) (State or country) Chestertown Md

PARENTS

10 NAME OF FATHER Asbury Howard

11 BIRTHPLACE OF FATHER (city or town) Chestertown (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Glenn

13 BIRTHPLACE OF MOTHER (city or town) Chestertown (State or country) Md

14 Informant Mrs R W Sampson (daughter) (Address) Chestertown Md

15 Filed JUN 8 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 7 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-26, 1922, to 6-7, 1922, that I last saw him alive on 6-7-22, and that death occurred, on the date stated above, at 7.45 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of urinary bladder (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of No 6-7-22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno Sadler M. D.

6-7, 1922 (Address) The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown - Md DATE OF BURIAL June 8- 1922

20 UNDERTAKER Stewart Howard Company ADDRESS 108 W Monument

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 64989

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64989

CERTIFICATE OF DEATH.

224-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 643 N. Conway ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius G. J. Gude

(Residence in Baltimore: No. 643 N. Conway St. St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May (Month) 20th (Day), 1853 (Year)

7-AGE, 69 yrs. mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Justice of the Peace
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Juetus Gude

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Do not know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Gude

(Address) 643 N. Conway

15- JUN 8 1922 ROBERT R. KRAUTER, Filed....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27 1922 to June 6th 1922 that I saw h[illegible]m alive on June 6th 1922 and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Carrick M. D.

June 7, 1922 (Address) 412 N. Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, June 10th, 1922.

20-UNDERTAKER Jos Joerdens, Son ADDRESS 217 S. Pres

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 64990 HEALTH DEPARTMENT—CITY OF BALTIMORE D 64990

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1219 Argyle Ave, St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary Watkins

(Residence in Baltimore: No. 1219 Argyle Ave, St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): widow

6-DATE OF BIRTH: about (Month) (Day) 1858 (Year)

7-AGE: 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Cooper Stewart

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Lyle Hudson

13-BIRTHPLACE OF MOTHER, (State or Country): Lyle Hudson

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Watkins

(Address) 1219 Argyle Ave

15- Filed JUN 8 - 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 8, 1922 (Address) 2302 Eutaw Pl

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: June 9, 1922

20-UNDERTAKER: Samuel Wensley & Bro ADDRESS 578

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64991

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1001 Roland Heights Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Louise Bartholow

(a) RESIDENCE. No. 1001 Roland Heights Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer Miss Agnes McGovern

9 BIRTHPLACE (city or town) (State or country) Carroll Co.

PARENTS

10 NAME OF FATHER Thos. B. Barthalou

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co.

12 MAIDEN NAME OF MOTHER Alice Jordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co.

14 Informant Mrs. Jess Bengel
(Address) 1001 Roland Heights Ave.

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1922, to June 7, 1922, that I last saw her alive on June 6, 1922, and that death occurred, on the date stated above, at 3.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of "

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Cooledge, M. D.

6/8 1922 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co Md. Mt. Pleasant Cem. DATE OF BURIAL June 9 1922

20 UNDERTAKER Martin Brake & Sons ADDRESS 1827 W North Ave

JUN 8 - 1922

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64992

CERTIFICATE OF DEATH.

100-001

D 64992

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 2 WARD)

2-FULL NAME Theodore Jackson

(a) RESIDENCE NO. 228 S. Durham St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 19 22

17 I HEREBY CERTIFY, That I attended deceased from October 3, 1917, to June 5, 19 22.

that I last saw him alive on June 5, 19 22.

and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Neal, M. D.

6/6/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JN 8 1922

B.—WRITE PLAINLY, WITH INK. All information should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Wagny M. Lindefelt) ✓

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64993

D 64993

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3026 (Street) Windsor Ave (WARD) 15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wagny M. Lindefeldt

(a) RESIDENCE NO. 3026 Windsor Ave (Street) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 16-1903

7 AGE — Years: 18 Months: 9. Days: 21 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

800

9 BIRTHPLACE (city or town) (State or country): Sweden.

PARENTS

10 NAME OF FATHER: Andrew Lindefelt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Lina Nickolos

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Emma T. Hansen

(Address) 3026 Windsor Ave

15 Filed June 8 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1922, to June 6, 1922, that I last saw h[illegible] alive on June 6th, 1922, and that death occurred, on the date stated above, at 6.00 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(following pulmonary hemorrhage of tuberculor origin)

(duration) 0 yrs. 0 mos 6 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? No Sputum test made

(Signed) S A Dodds, M. D.

June 8 1922 (Address) 3101 Clifton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 9 1922

20 UNDERTAKER: W E Lechner & Son — ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 8 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64994

D 64994

CERTIFICATE OF DEATH.

118-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 17 WARD)

2-FULL NAME Mr Howard Walker.

(a) RESIDENCE NO. 1615 N Calvert st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent 086

(b) General nature of industry, business, or establishment in which employed (or employer) advertizing

(c) Name of employer –

9 BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10 NAME OF FATHER Wm H Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Linda B Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Miss E H Walker

(Address) 1615 N Calvert st

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

JUN 8 – 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1922, to June 6, 1922, that I last saw h.i.m alive on June 6, 1922, and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis following and operation for intestinal obstruction.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Following operation for obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. W. Swift M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cem	6/27 19
UNDERTAKER	ADDRESS
Geo A Tilley Sons	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of Occupation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 64995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64995

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 E Belvedere Ave (WARD) 27

2-FULL NAME William H Smith

(a) RESIDENCE NO. 102 E Belvedere Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower of Isabella F Smith

6 DATE OF BIRTH (month, day, and year): Jan 17 1848

7 AGE: Years 73 Months 4 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer: Savings Bank of Balto

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel H Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Norman H Bortner (Address) 102 E Belvedere Ave

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1921, to June 7, 1922.

that I last saw h[e] alive on June 6, 1922

and that death occurred, on the date stated above, at 1450 m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter W. White M. D.

6/8, 1922 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 10 1922

UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. White 2800 St Paul St [illegible] (Clerk)

Spec.—1-10-21—M&T—1500 Bks.

D 64996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64996

CERTIFICATE OF DEATH.

H 3

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Alfred Groot.

(a) RESIDENCE NO. 832 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27 1874

7 AGE — Years: 48 yrs. Months: 6 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Keys

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Zinkraue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant (Address) John Groot 600 N. North Ave

15 JUN 8 - 1922 ... 19 ... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8 1922.

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1922, to 6-8, 1922.

that I last saw h alive on 6-8, 1922.

and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to body

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination Inspection

(Signed) W. Wyatt Swett M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 10 1922

20 UNDERTAKER: William Lahr — ADDRESS: 502 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 64997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64997

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

2-FULL NAME Phillip Reuschling

(a) RESIDENCE NO. 2010 E. Hoffman St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Unknown~~ Mary Reuschling

6 DATE OF BIRTH (month, day, and year) ~~Unknown~~ Oct 28 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Phillip Reuschling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, Municipal Hospital.

15 JUN 8 1922 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to June 8, 1922, that I last saw him alive on June 8, 1922, and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

6/8/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem't | DATE OF BURIAL June 13 1922

20 UNDERTAKER William Buck | ADDRESS 3026 E Madison

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64998

CERTIFICATE OF DEATH.

162 D 64998

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Holebrook ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl Hammann

(a) RESIDENCE NO. 1402 Holebrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.
	—	June	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER John Hammann

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Goldberg Fannie Hammann

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Josephine Hammann (Address) 1402 Holebrook St.

15 Filed JUN 9 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from JUN 8 - 1922, 19..., to JUN 8 - 1922, 19...,

that I last saw h... alive on JUN 8 - 1922, 19...,

and that death occurred, on the date stated above, at 11½ m.

The CAUSE OF DEATH* was as follows:

Asphyxia in birth Canal

(duration) ^ yrs. ^ mos ^ ds.

CONTRIBUTORY (Secondary) prolapsed cord

(duration) ^ yrs. ^ mos. ^ ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) O H Dukes M. D.

JUN 8 - 1922 19 (Address) 928 E North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 9 1922

20 UNDERTAKER Frank A. Tinks — ADDRESS 913 W. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 64999

CERTIFICATE OF DEATH.

90 D 64999

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Mosher St ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Willis

(a) RESIDENCE. NO. 1004 Mosher St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Andrew Willis

6 DATE OF BIRTH (month, day, and year) Dec 12, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dillstown Pa.

PARENTS

10 NAME OF FATHER John Foner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Will

13 BIRTHPLACE OF MOTHER (city or town) Gettysburg (State or country) Pa.

14 Informant Mary Willis Bishop

(Address) 726 George St. near Paca St.

15 Filed JUN 9 - 1922 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to June 8, 1922, that I last saw her alive on June 5, 1922, and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows: Cardiac dilitation with decompensation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, pericarditis with adhesions (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? 1004 Mosher St

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? None.

(Signed) Harry D. McCarty, M. D.

, 19 (Address) 137 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 6/9/22 19

20 UNDERTAKER Cuddie M. Walker ADDRESS 723 W. Lafayette

D 65000

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65000

113 D 65000

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 938 Little Pine ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland Oliver

(Residence in Baltimore: No. 938 Little Pine St.; yrs., 3 mos. 24 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH: Feb. (Month) 12 (Day), 1922 (Year)

7-AGE: ....yrs. 3 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Herbert Oliver

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Ethel Mason

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Herbert Oliver

(Address) 938 Little Pine St.

15-

Filed ..... 191.....

JUN 9 - 1922

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mal Nutrition

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 8, 1922 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, June 9, 1922

20-UNDERTAKER Paul Eckert

ADDRESS 916 Pine

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65001

CERTIFICATE OF DEATH.

49 D 65001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Linden Ave ST., 12 WARD)

2-FULL NAME Fannie Eilau

(a) RESIDENCE No. 2408 Linden Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1860

7 AGE — Years: 61 — Months: 11 — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: David Eilau

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lena Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss. F. Eilau (Address) 2408 Linden Ave

15 Filed JUN 9 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/1922

17 I HEREBY CERTIFY, That I attended deceased from January, 1922, to June 7, 1922, that I last saw her alive on June 7, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lungs

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Oedema of lung

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? nv Date of ✓

Was there an autopsy? nv

What test confirmed diagnosis? clinical

(Signed) I Frederick Leit, M. D.

6/7, 1922 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. DATE OF BURIAL: 6/9/1922

20 UNDERTAKER: David Sondheim ADDRESS: 118 W. Mt. Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65002

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 W. Lombard ST.; 4 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Serkiewicz

(a) RESIDENCE. No. 634 W. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Serkiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Emma Norbet.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Joseph Serkiewicz (Address) 634 W. Lombard St.

15 Filed JUN 9 - 1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 1st, 1922, to June 7, 1922, that I last saw h alive on May 10, 1922, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Unresolved pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Woodruff, M. D.

, 19 (Address) 252 N. Payson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. DATE OF BURIAL: 6/9/ 19

20 UNDERTAKER: Geo. J. Ruth ADDRESS: 1735 Harford Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Letre

D 65003 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 65003
Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 1044 Granby St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salavatore Lethre.

(Residence in Baltimore: No. 1044 Granby, St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, ~~Married~~ ~~Widowed~~ ~~or Divorced~~ (Write the word.): Single

6-DATE OF BIRTH: May 15 (Month) (Day) 1922 (Year)

7-AGE: yrs. mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country): md.

PARENTS:
10-NAME OF FATHER: Paul Letre.
11-BIRTHPLACE OF FATHER, (State or Country): Italy.
12-MAIDEN NAME OF MOTHER: Vukmano
13-BIRTHPLACE OF MOTHER, (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Paul Letre.
(Address) 1044 Granby.

15-
Filed 192 ROBERT R. KRAUTLER, Registrar.
JUN 9 - 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June 8 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Immature
Rickets
(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)
(Address) 143 N Bond

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Vincent Cemetery — DATE OF BURIAL: June 9 1922

20-UNDERTAKER: George J. Ruth — ADDRESS: 1735 Hartford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65004

CERTIFICATE OF DEATH.

49 D 65004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 S. Potomac ST., 1 WARD)

2-FULL NAME John A. Ackerman

(a) RESIDENCE No. 501 S. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Ackerman

6 DATE OF BIRTH (month, day, and year) June 20-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	61	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 044

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Ackerman

(Address) 501 S. Potomac St

15 JUN 9 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17

I HEREBY CERTIFY, That I attended deceased from May — 1920, to June 6 — 1922,

that I last saw h— alive on June 6 — 1922

and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Malignant Dis- Abdominal (Splenic)

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Debility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos O Bonner, M. D.

, 19 (Address) 125 S Bdway —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	June 9 1922
20 UNDERTAKER	ADDRESS
R. Sander & Sons	1710 E Fed St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the naturo of the business or industry, and therefore an additional line is provided for the latter statement; it should bo used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always tho same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (diseaso causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite diseaso can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably originated in spleen

Spec.—1-10-21—M&T—1500 Bks.

D 65005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65005

CERTIFICATE OF DEATH.

101 001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gross

(a) RESIDENCE No. 629 N. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Eliza Gross

6 DATE OF BIRTH (month, day, and year) Apr. 9 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER George Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Mercy Hospital Records (Address)

15 Filed JUN 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922 to June 7, 1922

that I last saw him alive on June 7, 1922

and that death occurred, on the date stated above, at 4:45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) John L. Erwin M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL June 10 1922

20 UNDERTAKER John H. Tradum — ADDRESS 142 Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65006

HEALTH DEPARTMENT—CITY OF BALTIMORE

001
100

D 65006

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Carroll St., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Delgris Benner

(a) RESIDENCE NO. 1426 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm E. Benner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Nannie Marsh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Wm E Benner
(Address) 1426 Carroll St

15 JUN 9 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/8/22, 19..., to 6/8/22, 19...,
that I last saw h — alive on 6/8/22, 19...,
and that death occurred, on the date stated above, at 8 30 m.
The CAUSE OF DEATH* was as follows:

DDD

Bronchio Pneumonia,

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Heyward Dean, M. D.

6/9-, 1922 (Address) Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: 6/9 1922

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Eathorn Hollins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of varlous pursuits can be known. The question applies to each and every person, Irrespectlve of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But In many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65007

CERTIFICATE OF DEATH.

D 65007

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1024 Patapsco St. ST., 23 (WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Waters.

(a) RESIDENCE No. 1024 Patapsco St. ST., WARD 23
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William H. Waters.

6 DATE OF BIRTH (month, day, and year) Dec, 25th. 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Kunzman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant William H. Waters. (husband)
(Address) 1024 Patapsco St.

15 Filed JUN 9- 1922 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th. 19 22.

17 I HEREBY CERTIFY, That I attended deceased from May 19th., 19 22., to June 8th., 19 22.,
that I last saw her alive on June 7th., 19 22.;
and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nebhritis.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto Reinhardt M. D.

6/8. 19 22 Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL June 12 1922

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65008 HEALTH DEPARTMENT--CITY OF BALTIMORE

D 65008

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1913 E. 32nd St. St.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Frederick Arndt.

(Residence in Baltimore: No. 1913 E. 32nd St. St.: yrs. 42 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: (Month) Aug (Day) 3, (Year) 1869

7 AGE: 52 yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Steam fitter
(b) General nature of industry, business, or establishment in which employed (or employer): repairs. 086

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jacob Frederick Arndt

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elenor Mantz

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Arndt

(Address) 1914 Wilson ave

15 Filed JUN 9-1922 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 8 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1922 to June 8 1922

that I saw h[illegible] alive on June 8, 1922

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia - chronic (Bright's disease)

(Duration) yrs. mos. 12 ds

Contributory (SECONDARY) Oedema of lungs

(Duration) yrs. mos. 3 ds.

(Signed) Fernando C. Dreyer M. D.

June 9, 1922 (Address) 904 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: June 10, 1922

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D 65009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 65009

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Frederick Huff ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 524 N Patterson Pk Ave

(Residence in Baltimore: No. 524 N Patterson Pk Ave St.; Life yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 23, 1873 (Month) (Day) (Year)

7-AGE, 48 yrs. 6 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 086

(a) Trade, profession, or particular kind of work: Broom Maker

(b) General nature of industry, business, or establishment in which employed (or employer): J. L. Hill

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Huff

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Dorger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. L. Hill

(Address) 524 N. Patterson P. Ave

15- JUN 9-1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1922, to June 7 1922, that I saw him alive on June 6 1922, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 1 mos. ds.

(Signed) Wilbur C. Hayes M. D.

6/8, 1922 (Address) 2600 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, June 9, 1922

20-UNDERTAKER Wm C. Miller — ADDRESS 2384 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65010

CERTIFICATE OF DEATH.

10 D 65010

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST.: 73 WARD)

2-FULL NAME Howard Walters

(a) RESIDENCE. NO. 1604 Light St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30-1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Elmer Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Fannie Owens.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mr. Walters 1604 Light St.

15 Filed JUN 9-1922 19 J. C. Mehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7. 1922 to June 8. 1922.

that I last saw him alive on June 8. 1922.

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, pharyngeal.

(duration) 0 yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Post diphtheritic paralysis

(duration) 0 yrs. 0 mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B. Macgregor, M. D.

(Address) Sydenham Hospital June 9/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL 6/9-22

20 UNDERTAKER J. F. & H. Emily ADDRESS 130 E. Fay

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65011 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D 65011

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2556 Wilkins Ave. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Schaeffer

(a) RESIDENCE. No. 2556 Wilkins Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ... should state ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Schaeffer

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Adam Schaeffer

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lena Herrich

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Carrie Schaeffer
(Address) 2556 Wilkins Ave.

15 Filed JUN 9 - 1922 H. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from December 17 1921, to June 8, 1922, that I last saw him alive on June 8, 1922, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Auto-intoxication

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan, M. D.

6/8/1922 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetary	June 10 1922

20 UNDERTAKER C. D. Thurgent ADDRESS 2236 Fred. Ave

Spec.—1-10-21—M&T—1500 Blks.

D 65012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65012

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. #229 Linden Ave ST. 70 WARD)

2-FULL NAME Frederick A Heck

(a) RESIDENCE NO. 229 Linden ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 2 1908

7 AGE — Years: 14 — Months: 1 — Days: 6 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Ernest Heck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Rinaldi Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Ernest Heck 229 Linden Ave

15 Filed JUN 9 1922 19 ..... F E Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922 to June 7 1922

That I last saw him alive on June 6 1922 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrh

(duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

6/7 1922 (Address) 1027 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 10 1922

UNDERTAKER: F B Shepherd — ADDRESS: 226 Fred'k Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S Smallwood ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm F. Brosman

(a) RESIDENCE NO. 406 S Smallwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma J. Brosman

6 DATE OF BIRTH (month, day, and year) Sept 3rd 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bristle Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Wm Wilkens Hair

(c) Name of employer Factory

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Hugley Brosman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Gelb

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Emma J. Brosman
(Address) 406 S Smallwood

15 Filed JUN 9 - 1922 F. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to June 6, 1922,

that I last saw him alive on June 6, 1922,

and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia. Atherosclerosis.

Endocarditis. OTEN

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Nitsch M. D.

6/8, 1922 (Address) 2151 Wilson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 8 1922

20 UNDERTAKER F B Nesbitt

ADDRESS 2336 Frederick Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 65014

CERTIFICATE OF DEATH.

D 65014

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 Hampden Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen Columbus Brown.

(a) RESIDENCE. No. 638 Hampden Ave ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Brown.

6 DATE OF BIRTH (month, day, and year) 2/1 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Montgomery Co Md

PARENTS

10 NAME OF FATHER Owen Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co Md

12 MAIDEN NAME OF MOTHER Elizbeth Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co.

14 Informant Mrs Harriet Miles

(Address) 635 Hampden ave Belton Md

15 JUN 9 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8 1922 to June 8 1922

that I last saw h alive on June 8 1922

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Left - Hemiplegia, with post mortem determination

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General symptoms

(Signed) C. B. Norment M. D.

19 (Address) 3643 Canterbury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Chapel Hounds	June 10 1922
20 UNDERTAKER	ADDRESS
James M Ficklen & Son	Woodbine Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably apoplectic

Spec.—1-10-21—M&T—1500 Bks.

D 65015 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65015

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James White

(a) RESIDENCE No. 2218 Pennsylvania ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca White

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Chas. White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records,
(Address): Municipal Hospital.

15 Filed JUN 9 - 1922 ROBERT R. KNAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 11, 19 22 to June 7, 19 22,

that I last saw him alive on June 7, 19 22,

and that death occurred, on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH* was as follows:

Tubercular sinuses of back & pelvis -

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sepsis. ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Jos. Brumbach M. D.

6/7/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Del

DATE OF BURIAL: June 9 1922

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (...origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Pott's Disease
Probably old
pulmonary tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65016 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65016

CERTIFICATE OF DEATH. 131

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 N Caroline ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances A. Sheats

(a) RESIDENCE. No. 1709 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas L. Sheats

6 DATE OF BIRTH (month, day, and year): July 2 1845

7 AGE: Years 76 Months 11 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Hiram Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Cecilia Sparklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Thomas L. Sheats Jr

(Address): 3800 Foust Park ave

15 Filed JUN 9 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19 - , 1922, to June 8 - , 1922, that I last saw her alive on June 7 - , 1922, and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, Nephritis, Cardiac insufficiency & Uremal Toxemia

(duration) about seven weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia & Convulsions about 12 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Carlton M. Cook, M. D.

1922 (Address) 1107 Lanvale st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 10 1922

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 N. North ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D 65017

D 65017

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 516 N. Loudon (Ave.) St. 20 WARD)

2-FULL NAME James L. Ward.

(a) RESIDENCE. NO. 516 N. Loudon St. Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of Helen Langan

6 DATE OF BIRTH (month, day, and year) Unknown 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab'r.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant My Wm. Ward.

(Address) 516 N. Loudon Ave

15 FILED JUN 9 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to June 7, 1922, that I last saw him alive on June 6, 1922, and that death occurred, on the date stated above, at 1150 a m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar E. Travers M. D.

, 19 (Address) 1520 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem.	June 10 1922
20 UNDERTAKER Foley J. Howard & Son.	ADDRESS
per J. J. Howard	901 Hollins

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

Doty

D 65018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 65013

REGISTERED NO.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cordelia Doty

(a) RESIDENCE NO. 37 Wickford Rd. ST., Guilford - Cit. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 2 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert M. Doty

6 DATE OF BIRTH (month, day, and year): 3-11-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	38	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Syracuse N.Y.

PARENTS

10 NAME OF FATHER: Hugh Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary J. McClure

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 9 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to June 8, 1922, that I last saw h alive on June 8, 1922, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor 2
Glioma

(duration) 8 yrs. — mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? partial (Hist)

What test confirmed diagnosis? Clinical

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: June 10 1922

20 UNDERTAKER: Chenoweth & Son — ADDRESS: Edmondson Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65019

D 65019

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Essa Rice

(Residence in Baltimore: No. St. Joseph's Hosp. St.; ....yrs. ....mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 15th, 1893
(Month) (Day) (Year)

7-AGE, 29 yrs. ... mos. 27 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Monaskon Va.

PARENTS.

10-NAME OF FATHER, John Miller

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Wesley

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Rice

(Address) Monaskon Va.

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

JUN 9 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1922, to June 9 1922, that I saw h&R alive on June 9 1922, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis.

(Duration) 1 yrs. ....mos. ....ds.

(Signed) J. J. Schenwick M. D.

June 10, 1922 (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State ....yrs. ....mos. 3 ds.

Where was disease contracted, if not at place of death? Virginia

Former or usual residence Alphonso, Va.

19-PLACE OF BURIAL OR REMOVAL, Monaskon Mbl. Va

DATE OF BURIAL, 6/9/22, 191...

20-UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Hartford

Burial Permit

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 65020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117

D 65020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 11 WARD)

2-FULL NAME Mrs. Maude R. Anderson

(a) RESIDENCE No. The Cecil Apts Baltimore Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 9. 1875

7 AGE: Years 46 | Months 7 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER George Raybird

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Mary Duggan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Mercy Hospital Records (Address)

15 Filed JUN 9 - 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to June 9, 1922

that I last saw her alive on June 9, 1922

and that death occurred, on the date stated above, at 10:10 a. m.

The CAUSE OF DEATH* was as follows:

Ruptured Gangrenous appendicitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Appendectomy Date of May 8, 1922

Was there an autopsy? None

What test confirmed diagnosis? Findings, Physical Signs Symptoms

(Signed) John J. Erdmann, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: May 10 1922

20 UNDERTAKER: Wm. J. Eichelberger ADDRESS: Norfolk Va.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65021

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 16 Overhill Road St. Roland Park WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robert Hagerty

(a) RESIDENCE. No. 16 Overhill Road St. Roland Park WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: E. Cora Swindell

6 DATE OF BIRTH (month, day, and year): May 2nd 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 845

(b) General nature of industry, business, or establishment in which employed (or employer): Tin Merchant.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James S. Hagerty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: E. J. Smiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: George E. Hagerty (Address) New York

15 Filed JUN 9-1922 Robert P. Harrison, Registrar

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7. 1922. to June 8 1922. that I last saw h. m alive on June 8 1922. and that death occurred, on the date stated above, at 8 A. m.

DEATH CAUSE OF DEATH* was as follows:

Right inguinal hernia, possible strangulation. Bowel in scrotum with swelling of penis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cedric Hardening's

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Porter, M. D.

6/8. 1922 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	June 10 1922

20 UNDERTAKER: A. Jenkins & Son Co. ADDRESS: Orchard & Fulton Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65022

CERTIFICATE OF DEATH.

D 65022

REGISTERED NO. 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Friendship ST., 13 WARD)

2-FULL NAME Mary E Shaffer

(a) RESIDENCE No. 1709 Friendship ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew S Shaffer

6 DATE OF BIRTH (month, day, and year): May 15 1856

7 AGE: Years 66; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At

(b) General nature of Industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Rachel Beard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm L Shaffer (Address) 1715 Friendship St

15 Filed Jun 19 22 Robert J. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from 2-1-1922, to 6-7-1922, that I last saw her alive on 6-1-1922, and that death occurred, on the date stated above, at a.m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis (Interstitial)

(duration) 1/2 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Cardiac Insufficiency.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam & Microscopic

(Signed) William Henry Sargent M. D.

6-9-1922 (Address) 1928 N Fulton Ave Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem DATE OF BURIAL: June 10 1922

20 UNDERTAKER: Wm Cook ADDRESS: 502 E Mt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-9-1922 Buffalo 1928 N Fulton Ave.

D 65023 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 7 E. Wylie Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M. Kolofos

(Residence in Baltimore: No. 7 E. Wylie Ave St.; yrs. Lif mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH, August 22, 1921 (Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Sam L. Kolofos

11-BIRTHPLACE OF FATHER, (State or Country), Greece

12-MAIDEN NAME OF MOTHER, Ethel M. Mgbee

13-BIRTHPLACE OF MOTHER, (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel M. Kolofos

(Address) 7 E. Wylie Ave.

15- Filed ..... 192.... Registrar.

Robert P. Harrison, Burial Permit Clerk.

JUN 9 - 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D. (Coroner.)

....., 192.... (Address) .....

*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Stone Chapel	June 10, 1922
20-UNDERTAKER,	ADDRESS
Wm. Cook	502 E. Monument

WRITE PLAINLY, WITH UNFADING INK.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1882 1002 D 65024

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 500 block Mosher St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Elizabeth Redmond

(Residence in Baltimore: No. 564 W. Mosher St.; 4 yrs., 7 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) single

6-DATE OF BIRTH, Nov. 24, 1915 (Month) (Day) (Year)

7-AGE, 4 yrs. 7 mos. 12 ds. If LESS than 1 day, ...hrs. or....mlu.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Hurley Redmond

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Alice Fletcher

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... mrs. alice Redmond

(Address)..... 564 W. Mosher St.

15-

Filed..... 192.....

1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken neck (Instantaneous death)

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Street car accident.

(Duration)..... yrs..... mos..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 9 192 2 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral Cem. 6-10 1922

20-UNDERTAKER, ADDRESS

George H. Hollins 1631 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65025

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1918 D 65025

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fallo, near Pratt St. ST. 10 WARD)

2-FULL NAME James a. O'Donnell (O'Donnell)

(Residence in Baltimore: No. 1407 Anthony St, St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, March (Month) 18 (Day) 1908 (Year)

7-AGE, 14 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John O'Donnell

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Sarah Keisler

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah O'Donnell

(Address) 1407 Anthony

15-

Filed ....Robert J. Harrison,
1918 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day), 1918 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned - accidentally fell in water

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

June 9, 1918 (Address) 1637 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1/3 yrs. less mos. ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	June 12, 1918

20-UNDERTAKER Henry Hosch Son ADDRESS 1301 E Eager St

D 65026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65026

CERTIFICATE OF DEATH.

168

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 507 N. Exeter St.; WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua G. Woodward

(Residence in Baltimore: No. 507 N. Exeter St.; Ward 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	colored	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 56 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hackman
(b) General nature of industry, business, or establishment in which employed (or employer): Hack

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Woodward

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER Sarah Fields

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. M. Maynard

(Address) 1113 N. Eden

15-

Filed ..... Robert P. Harrison, ...
Registrar.

UN 10 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9 (Month) (Day), 1922 (Year) (Found dead)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging
while demented.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
June ..., 1922. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery | DATE OF BURIAL, June 10, 1922

20-UNDERTAKER Henry Hoch & Son | ADDRESS 1301 E. Eager

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

6.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65027

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 S. Second ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Virginia Frisch

(a) RESIDENCE No. 833 S. Second ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9/22

7 AGE — Years — Months — Days — If LESS than 1 day, 4 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER John F. Frisch

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Pa.

12 MAIDEN NAME OF MOTHER Lillian V. Phillips

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant: John F. Frisch (Address) 833 S. 2nd.

15 JUN 10 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to June 9, 1922, that I last saw her alive on June 9, 1922, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth - (7th month gestation).

(duration) yrs. mos. 4 hrs.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. 4 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. J. Lockwood, M. D.

, 19 (Address) 806 S. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: June 11 1922

20 UNDERTAKER: A. Sander & Sons — ADDRESS: 720 Flint St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65028

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 65028

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1327 Hull St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and oomber and fill out No. 18.)

2 FULL NAME Anna Bell.

(Residence in Baltimore: No. 1327 Hull St.: 72 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: November 13, 1846 (Month) (Day) (Year)

7 AGE: 77 yrs. 6 mos. 24 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Bohemia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Bell

(Address) 1327 Hull St

15. Filed JUN 1922, 191.... Robert P. Harrison, Registrar

Burial Permit Cl

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 7, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5-6, 1922, to June 7, 1922, that I saw h[illegible] alive on June 7, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Decompensated Aortic Regurgitation

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos F. Stevens M. D.

June 8, 1922 (Address) 2878 Harford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Oak Hill | DATE OF BURIAL: June 10, 1922

20 UNDERTAKER: [illegible] Bradley | ADDRESS: 1906 Eutaw Pl

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65029

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2530 Eager Place ST.; 7 WARD)

2-FULL NAME Magdalene Knauer

(a) RESIDENCE. NO. 2530 Eager Place ST., ... WARD. .....
(Usual place of abede) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John L. Knauer

6 DATE OF BIRTH (month, day, and year) May 7 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Seubert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Francis Jesenka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant John J. Knauer
(Address) 2530 Eager Place

15 Filed JUN 10 1922, 19... Registrar Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 19 22 to June 8, 19 22
that I last saw h alive on June 8, 19 22
and that death occurred, on the date stated above, at 2.10 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 10 mos. ... ds.

CONTRIBUTORY (Secondary) anemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Fundus

(Signed) M. Murphy M. D.

6-9-22 (Address) 800 N Dallas Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 12 1922
20 UNDERTAKER Frank Crackson	ADDRESS 1806 Eutaw Place

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65030

D 65030

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 18 W. 9th St. ST.: 23 (WARD)

2-FULL NAME Elizabeth N. Kaiser

(a) RESIDENCE. NO. 18 W. 9th St ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: William J. Kaiser

6 DATE OF BIRTH (month, day, and year): May 10, 1892

7 AGE — Years: 30 — Months: — Days: 27 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Lewis H. Lamm.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lenora Wilds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: J. William J. Kaiser
(Address): 18 W. 9th St

15 Filed ..... 19..... Robert F. Garrison, Registrar

JUN 1 0 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jun 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jun 5, 1922 to Jun 9, 1922, that I last saw h alive on Jun 9, 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Subacute yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell, M. D.

Jun 9, 1922 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hollow	June 12 1922
20 UNDERTAKER	ADDRESS
M. J. Evans	1412 Pine

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65031

CERTIFICATE OF DEATH.

D 65031

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Ward ST., 21 WARD)

2-FULL NAME Robert Vaughn

(a) RESIDENCE NO. 1427 Ward ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 5, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Robert Vaughn

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Mildred Conway

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mildred Conway
(Address) 1427 Ward St

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk

JN 1 01922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 8, 1922

that I last saw h[illegible] alive on June 8, 1922

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. Fray, M. D.

6/9, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL June 10 1922

20 UNDERTAKER Samuel Wright — ADDRESS 364 N Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65032 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65032

CERTIFICATE OF DEATH.

REGISTERED No. C 161

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1021 - So. 3rd St. W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Bottlemace

(Residence in Baltimore: No. 1021 So. 3rd St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 7th (Day) 9 am. (Year) 1922

7-AGE, ...yrs. ....mos. 1½ ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, George Bottlemace

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Johanna Pfeil

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johanna Pfeil

(Address) 1021 - So. 3rd St

15-

Filed ....., 191.... Robert F. Harrison, Registrar.

Burial Permit Clerk.

JUN 10 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8th (Day) 9 P.M. (Year) 1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

.... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. B. Hatton M. D. (Coroner)

June 9th, 1922 (Address) Curtis Bay, Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. DATE OF BURIAL, June 10, 1922

20-UNDERTAKER Lilly & Zeile ADDRESS 4038 Wolfe

INSTRUCTIONS.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65033

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 65033

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2432 E. Biddle St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Drury

(Residence in Baltimore: No. 2432 E. Bidale St.; yrs. 37 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

6-DATE OF BIRTH, October (Month) 28 (Day) 1887 (Year)

7-AGE, 37 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 048
(b) General nature of industry, business, or establishment in which employed (or employer) employed by City of Balto

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Drury

11-BIRTHPLACE OF FATHER, (State or Country) Balto md

12-MAIDEN NAME OF MOTHER, Elizabeth Neal

13-BIRTHPLACE OF MOTHER, (State or Country) Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geneva

(Address) 2432 E. Biddle St.

15-

Filed 1922 Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Lesion

Contributory

Postmortem (Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Patterson M. D.
(Coroner.)

June 8 1922 (Address) 708 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, June 12 1922

20-UNDERTAKER, John Boyce & Son ADDRESS 701 Hollins

Bur. of Edward 51

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNFO

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65034

D 65034

CERTIFICATE OF DEATH.

H1

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Benton

(a) RESIDENCE. No. 1002 Boyd ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lena Simons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Hospital Records
(Address)

15 Filed JUN 6 1922, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922 to June 9, 1922

that I last saw h alive on June 9, 1922

and that death occurred, on the date stated above, at 8.50 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar, Left Lung

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1002 Boyd St

Did an operation precede death? Yes Date of June 8, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Jones, M. D.

6/9, 1922 Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 12 1922
20 UNDERTAKER John F. Cowgur & Son Per J. H. Cowgur	ADDRESS 901 Holliday St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65035 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65035

CERTIFICATE OF DEATH.

Registered No. C 18,208

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William Seipp

(Residence in Baltimore: No. 106 S. Addison St.; yrs. 2 mos. 3 ds. 23)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. February 16 1920
(Month) (Day) (Year)

7-AGE, 2 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Charles Seipp

11-BIRTHPLACE OF FATHER, (State or Country), Phila. Pa

12-MAIDEN NAME OF MOTHER, Hattie G. Seipp

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hattie G. Seipp

(Address) 106 Adison St

15- Robert P. Harrison,

Filed ..... 192.....

1922 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said investigation
(Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

crushed abdomen & thorax
injuries by Garbage cart
accident

(Duration) ....yrs. ....mos. 1/1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Finlen M. D.
(Coroner.)

June 8 1922 (Address) 700 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. 1/1 ds.

Where was disease contracted, if not at place of death? from 106 S. Addison St

Former or usual residence. 106 S. Addison St

19-PLACE OF BURIAL OR REMOVAL. London Park DATE OF BURIAL. June 12 1922

20-UNDERTAKER. George C. Schwab ADDRESS 701 Cathedral St

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 65036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65036

128

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. [illegible] WARD)

2-FULL NAME Mary L. Hildebrand

(a) RESIDENCE. No. Baltimore - 31 E. North ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? Don't Know yrs. Know mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Hildebrand

6 DATE OF BIRTH (month, day, and year) May 8th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (?)
(State or country) Canada

PARENTS

10 NAME OF FATHER Charles Albert

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) France

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) (?)

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Retreat -

15 Robert P. Harrison, Registrar

Burial Permit No. [illegible]

JUN 10 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25th, 19 22, to June 9, 19 22,

that I last saw h[illegible] alive on June 9, 19 22,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

abt (duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute mania -

abt (duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank F Lamm, M. D.

, 19 (Address) Mount Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 12 1922
20 UNDERTAKER	ADDRESS
Isaiah Styer	1600 W North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65037

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3013 Penna Av ST., 13 WARD)

2-FULL NAME Mrs Eliza May Adams

(a) RESIDENCE NO. 3013 Penna Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Adams

6 DATE OF BIRTH (month, day, and year) May 10 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Thayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Nancy Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Geo. H. Adams

(Address) 3013 Penna. Av.

15 Robert P. Harrison, 19

Registrar

Burial Permit Clerk.

JN 1 01922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17

I HEREBY CERTIFY, That I attended deceased from 2 yrs; 19..., to June 9, 1922, that I last saw h[illegible] alive on June 8, 1922, and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Dis

Following Rheumatism

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Viscera

(Signed) B. H. Smith M. D.

6/9, 1922 (Address) 1057 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnell's Cem. Balto Co

DATE OF BURIAL June 11 1922

20 UNDERTAKER Josiah Lyser

ADDRESS 1600 or 1602 N Carey St

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65038

D 65038

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Gloverst. ST., 7 WARD)

2-FULL NAME Helen Jos. Lehmeyer

(a) RESIDENCE NO. 808 N. Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item & information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Nov 8 1921

7 AGE — Years: — Months: 7 Days: 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jos. John Lehmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Beckmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs Anna Lehmeyer

15 Filed JUN 1 1922 Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/8/ 1922.

17 I HEREBY CERTIFY, That I attended deceased from May 12 1922 to June 8 1922

that I last saw him alive on June 8 1922

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Meyer Jr. M. D.

6/8/ 1922 (Address) 2138 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: June 10 1922

20 UNDERTAKER: John Ullrich

ADDRESS: 2008 Aliceanna

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65039

CERTIFICATE OF DEATH.

164 D 65039

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Gough St ST.: 3 WARD)

2-FULL NAME Harry Rosenblatt

(a) RESIDENCE. No. 1426 Gough St ST., 3 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 93 Months 2 Days 2 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Samuel Rosenblatt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rosenbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Israel Rosenblatt
(Address) 1526 Gough St

15 Filed JUN 10 1922 Robert P. Garrison, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to June 9, 1922, that I last saw h. alive on June 9, 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Senility

Contributory Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine, M. D.

June 10, 1922 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rising Sun — DATE OF BURIAL: 6/11 1922

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E Baltimore St

JUN 10 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65040

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 W Conway ST. 77 WARD)

2-FULL NAME Geo. C. McMurray

(a) RESIDENCE NO. 612 Conway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. McMurray

6 DATE OF BIRTH (month, day, and year) 3/30/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) — 015

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER John McMurray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Isabelle Essender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant (Address) Mary C. McMurray 612 W. Conway St.

15 JUN 10 1922, 19 Registrar

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1922, to June 9, 1922,

that I last saw h[illegible] alive on June 8, 1922,

and that death occurred, on the date stated above, at [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 7 mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

6-9, 1922 (Address) 612 Conway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 6/12/1922

20 UNDERTAKER: Wm Coost, 502 E. North — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65041

D 65041

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 N Gay ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Flack

(a) RESIDENCE. No. 1749 N. Gay ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Flack

6 DATE OF BIRTH (month, day, and year) March 12 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
85	85	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Millerstown (State or country) Penna.

PARENTS

10 NAME OF FATHER Michael Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant (Address) Mrs. Chas. Lentz 1749 N. Gay St.

15 Filed 1922 Robt P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922, to June 10, 1922

that I last saw her alive on June 9, 1922

and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E E Herzog M.D.

6/10, 1922 (Address) 1306 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. DATE OF BURIAL: June 17, 1922

20 UNDERTAKER: Wm Cook ADDRESS: 502 E. North ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 65042

HEALTH DEPARTMENT—CITY OF BALTIMORE D 65042

CERTIFICATE OF DEATH.

REGISTERED NO. 15 113

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 3602 Park Dale Ave. ST. 15 WARD)

2-FULL NAME Joseph R. Boone

(a) RESIDENCE. No. 3602 Parkdale Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles R Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mable I Fantom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles R. Boone
(Address) 3602 Parkdale Ave

15 Filed June 10 1922 Robert P. Harrison, Registrar

1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17

I HEREBY CERTIFY, That I attended deceased from June 7 1922, to June 9, 1922, that I last saw h.... alive on June 8 1922, and that death occurred, on the date stated above, at 6.40 A m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [illegible] M. D.

June 10 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 10 1922
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(See affadavit over)

D 65043

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 65043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 E. Gleanure ave ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J Burkhardt

(a) RESIDENCE NO. 1 E. Gleanure ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1896

7 AGE: 25 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Port Jervis New York (State or country) N.Y.

PARENTS

10 NAME OF FATHER Geo C Burkhardt

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mamie McGuire

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant: Jos J Burkhardt (Address) 1 E. Gleanure ave

15 Filed JUN 10 1922 J.E.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1922 to Jan 8 1922

that I last saw him alive on June 8 1922

and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Avery M. D.

19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Woods Cemetery Dec

DATE OF BURIAL: June 12 1922

20 UNDERTAKER: Robt J Turner Sr

ADDRESS: 17 W. Conway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

June 19th, 1922.

This is to certify that George P. Burkhardt personally appeared before me this date and made affidavit that the birth place of Edward J. Burkhardt was given on death certificate # D65043 as Baltimore, Maryland, which is incorrect, as the same should be New York.

Geo P Burkhardt (father)

Fred Gaither

Notary

Spec.—1-10-21—M&T—1500 Bks.

D 65044 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65044

CERTIFICATE OF DEATH.

REGISTERED NO. 112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Division ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert James Christopher

(a) RESIDENCE NO. 1814 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Odessa Christopher

6 DATE OF BIRTH (month, day, and year) Aug 4, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	32	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Va.

PARENTS

10 NAME OF FATHER Charles Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sophronia Kirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Odessa Christopher (Address) 1814 Division St

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to June 8, 1922, that I last saw h[illegible] alive on June 7, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Fiby, M. D.

6/9, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Va.

DATE OF BURIAL June 10 1922

20 UNDERTAKER Geo. H. Deems

ADDRESS 302 Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JN 10 1922 Burial Permit Clerk.

D 65045 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65045

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1730 W. Lexington St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Clara Elizabeth Mossgrove

(Residence in Baltimore: No. 1730 W. Lexington St.; 4 yrs., mos. ds.)

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. April (Month) 26th. (Day) 1838 (Year)

7-AGE. 84 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... NONE
(b) General nature of industry, business, or establishment in which employed (or employer)..... NONE

9-BIRTHPLACE, (State or Country). Zanesville, Ohio

PARENTS.

10-NAME OF FATHER, Samuel Marvin

11-BIRTHPLACE OF FATHER, (State or Country). Ohio

12-MAIDEN NAME OF MOTHER, Miss Lottridge

13-BIRTHPLACE OF MOTHER, (State or Country). U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest H. Mossgrove

(Address) 1730 W. Lexington St.

15-

Filed JUN 10 1922

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture L. hip. due to fall on floor. Also attack of Uraemia accident

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) James H. Fenlon M. D. (Coroner.)

June 10 1922 (Address) 709 E Clare St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? X AT HOME

Former or usual residence. 1730 W. Lexington St.

19-PLACE OF BURIAL OR REMOVAL, Canton, Ohio DATE OF BURIAL, June 10 1922

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Bond St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65046

CERTIFICATE OF DEATH.

66 D 65046

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bay View ; ST.: ; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Peoples

(Residence in Baltimore: No. 107 Winter St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Toadvin

(Address) 142 W. Hill St

15-

Robert P. Harrison, ...

....., 191.....

Registrar.

Burial Permit [redacted]

UN 10 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, and
(Inquest, autopsy or inquiry.)
find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

..... (Duration) ..... yrs. ..... ds.

(Signed) Thos. P. Worthington M. D.
(Coroner)

June 10 1922 (Address) [redacted] Baltimore Md

*State the DISEASE CAUSING DEATH, or, if arising from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, June 10 1922

20-UNDERTAKER John H. Toadvin

ADDRESS 142 Hill St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should name CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65047

CERTIFICATE OF DEATH.

D 65047

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 P. Charles ST., 23 WARD)

2-FULL NAME Martha L. Hart.

(a) RESIDENCE No. 1318 P. Charles ST., 23 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4th yrs. 6 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of widow Arthur J. Hart

6 DATE OF BIRTH (month, day, and year) May 19 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... retired

(b) General nature of industry, business, or establishment in which employed (or employer) ..... — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Todie Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Jamison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Edward Hart
(Address) 1820 N. Mosher St

15 Filed JUN 11 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 19 22

17

I HEREBY CERTIFY, That I attended deceased from Mar. 21, 19 22, to June 10, 19 22, that I last saw her alive on May 10, 19 22 and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

about

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robt. C. Schleich, M. D.

10, 19 22 (Address) 1318 P. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL June 12 19 22

20 UNDERTAKER A S Marshall ADDRESS 3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

65047 D 65048

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65047 90 D 65048

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 407 S Central ave ST., 3 WARD)

2-FULL NAME Cecilia Esler

(a) RESIDENCE NO. 407 S Central ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: John H Esler

6 DATE OF BIRTH (month, day, and year): January 5 1867

7 AGE — Years: 55 — Months: 5 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House keeping

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Patrick Hamill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Orland

12 MAIDEN NAME OF MOTHER: Anna Hamill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Orland

14 Informant (Address): Ida Stevens 407 S Central ave

15 Filed ... 19 ... Robert F Garrison, Registrar

JUN 11 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1922

17

I HEREBY CERTIFY, That I attended deceased from July 14 - 1921 to June 8 - 1922

that I last saw her alive on June 8 1922

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Valvular - Cardiac Disease

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Pneumonia - Left Lung

(duration) 2 yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) ... M. D.

, 19 (Address) 1250 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 12 1922

20 UNDERTAKER: Wendell Duffel & Son — ADDRESS: 378 [illegible]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D 65049 ~~D 65048~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D 65048~~ D 65049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1433 Eastern ave ST. 3 WARD)

2-FULL NAME Rose Hogg

(a) RESIDENCE NO. 1433 Eastern ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas H Hogg

6 DATE OF BIRTH (month, day, and year) Nov 2 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer) ~~000~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orland

PARENTS

10 NAME OF FATHER Luch Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Orland

12 MAIDEN NAME OF MOTHER Bridget Linshy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Orland

14 Informant Mongo Schanz

(Address) 1433 Eastern ave

Filed JUN 11 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to June 9, 1922, that I last saw h[illegible] alive on June 9, 1922, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Paresis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Lee Mayness, M. D.

6.9. 1922 (Address) 1706 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Bathrudal — DATE OF BURIAL June 13 1922

20 UNDERTAKER Wendell Dyer & Son — ADDRESS 878 Mon

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65049 D 65050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65050

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp. St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert J. Carey

(Residence in Baltimore: No. 619 E. 30th St. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 31 (Day), 1877 (Year)

7-AGE, 45 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) National B. Sup Co

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael Carey

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Mary Boylan

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Carey

(Address) 619 E 30th St

15-

Filed JUN 11 1922, 191....

Robert P. Harrigan, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1922, to June 9 1922, that I saw h.. alive on June 9 1922, and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcers perforated & Peritonitis

(Duration) ....yrs. ....mos. 4 ds.

(Signed) S. W. J. Kenney M. D.

....., 191... (Address) St. Joseph Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents

DATE OF BURIAL, June 12, 1922

20-UNDERTAKER E. A. Windsor Jr

ADDRESS 501 E 22nd

N.B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 65051

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 585 N. Gay St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Israel Weinberg

(Residence in Baltimore: No. 585 N. Gay St St.; yrs. 22 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

6-DATE OF BIRTH: November (Month) (Day) 1880 (Year)

7-AGE: 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Garments

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Morris Weinberg

11-BIRTHPLACE OF FATHER, (State or Country): Russia

12-MAIDEN NAME OF MOTHER, (5) Sara Lubkowsky

13-BIRTHPLACE OF MOTHER, (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levin

(Address) 1439 E Balt

15-

Filed JUN 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Heart Lesion

(Duration) hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably - Intestinal Toxic Absorption (Duration) yrs. mos. ds.

(Signed) J. H. Patter M. D. (Coroner.)

6-9 1922 (Address) 50 E North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Hebrew Cem

DATE OF BURIAL, June 11 1922

20-UNDERTAKER: Jack Levin

ADDRESS 1439 E Balt

Spec.—1-10-21—M&T—1500 Bks.

D 65052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65052

CERTIFICATE OF DEATH

162

1-PLACE OF DEATH South Baltimore Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1213 Lyt ST., V WARD)

2-FULL NAME Baby Keith

(a) RESIDENCE NO. 1727 E Balto St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 10 1922

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Keith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ada Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 JUN 11 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922 to June 10, 1922, that I last saw him alive on June 10, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

30 min

(duration) ~~yrs.~~ ~~mos.~~ ~~ds.~~

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? (At home)

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Jno. Hutchinson M. D.

19 (Address) South Balto Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 6/11 1922

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

I. B. WRITE PLAINLY, and fill all blanks. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65053

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 65053

CERTIFICATE OF DEATH

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 400 N. Fulton Ave ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Sarah E. Clemens.

(Residence in Baltimore: No. Home for the Aged of the M E Church ST. 72 Yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	~~Married~~ Single

6-DATE OF BIRTH April (Month) 20 (Day), 1837 (Year)

7-AGE 85 yrs. 2 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10-NAME OF FATHER Jno D. Clemens.

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Susan Collison

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta Cuddy

(Address) Fulton ave and Franklin

15- ROBERT R. KRAUTER, Burial Permit Clerk. 191 REGISTRAR

N 11 1922

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June (Month) 10 (Day); 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to June 10 1922. that I saw h[er] alive on June 9 1922. and that death occurred, on the date stated above. at 3 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Hypostatic) 2d

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY) Endocarditis

(Duration) yrs. 8 mos. ds.

(Signed) George E. Shannon M. D.

June 10, 191 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL June 12, 1922

20-UNDERTAKER George J Smith

ADDRESS 1200 Pa. Ave. Fayette st

N-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C..... — D 65054

City of BALTIMORE: (No. St Agnes Hospital St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edna Schwartz

(Residence in Baltimore: No. Washington Boulevard Halow ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	single

6-DATE OF BIRTH. June (Month) 20 (Day) 1915 (Year)

7-AGE. 6 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School girl
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Frank J Schwartz

11-BIRTHPLACE OF FATHER, (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER. Florence E. Wade

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Schwartz

(Address) Washington Boulevard

15- Filed JUN 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 9 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull, Crushed Pelvis Internal Hemorrhage

(Duration).....yrs.....mos. 1/2 hr

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) James M. Heuber M. D. (Coroner.)

June 10 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Washington Boulevard Morrell Park

Former or usual residence Washington Boulevard

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. June 12 1922

20-UNDERTAKER, Jos Joerdens Son ADDRESS 217 S. Paca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65055

CERTIFICATE OF DEATH.

D 65055

113

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 N. Fairmount Ave ST., 19 WARD)

2-FULL NAME Mildred Mauskey

(a) RESIDENCE NO. 1510 N. Fairmount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Mauskey

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Chauncey Jordan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Chauncey Mauskey
(Address) 1510 W. Fairmount Ave

15 JUN 11 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7 - , 1922, to June 10 - 1922,
that I last saw h[illegible] alive on " , 19 ,
and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

acute Gastroenteritis

(duration) ..... yr. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition, Rickets

(duration) ..... yrs. 7 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? " .....

What test confirmed diagnosis? .....

(Signed) F. E. Candler M. D.

, 19 (Address) 1524 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL June 11th 1922

20 UNDERTAKER R Jones — ADDRESS 201 S Stricker St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Salem)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65056

D 65056

CERTIFICATE OF DEATH.

114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 W. Madison St. 11 WARD)

2-FULL NAME Edith Palm

(a) RESIDENCE NO. 313 W. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 23, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	3	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer) — 00

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Herman Palm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amanda Lange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. W. W. Davis

(Address) 1433 E. Eager St

15 Filed Robert P. Harris, 19

Registrar

JUN 11 1922 Burial Permit

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9 1922

17

I HEREBY CERTIFY, That I attended deceased from 6-7, 1922 to 6-9, 1922

that I last saw her alive on 6-9, 1922

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

6-10-22 19 (Address) 800 N Date St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem.

DATE OF BURIAL 6/12/ 19 22

20 UNDERTAKER Wm Cook

ADDRESS 507 E. Monument

D 65057

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

D 65057

1-PLACE OF DEATH — Registered No. C

CITY OF BALTIMORE (No. 3648 Old Fork Road St.; 9 Ward)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. C. A. Fields

(Residence in Baltimore: No. 3648 Old Fork Rd. St.; 82 yrs. 6 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: November 28th, (Month) (Day) 1839 (Year)

7-AGE: 52 yrs. 6 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Living at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore County

PARENTS

10-NAME OF FATHER: Richard Valentine

11-BIRTHPLACE OF FATHER (State or country): Lancaster England

12-MAIDEN NAME OF MOTHER: Ann Rogers

13-BIRTHPLACE OF MOTHER (State or country): Yorkshire England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice S Parkhurst

(Address) 1410 Park Ave

15- JUN 11 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June 9th, (Month) (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December, 1921, to June 9th, 1922, that I saw h[illegible] alive on June 9th, 1922, and that death occurred, on the date stated above, at 11:18 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 6 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Alice S. Parkhurst M. D.

June 9, 1922 (Address) 1410 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Olivet — DATE OF BURIAL: June 11th, 1922

20-UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65058 — 129 — D 65058

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Glenwood Av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Hartnagle

(Residence in Baltimore: No. 626 Glenwood Ave St.; 2 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 31 (Day), 1847 (Year)

7-AGE, 74 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manager
(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Store

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Philip Hartnagle

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Catherine Kayhyer

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Lewis Hartnagle

(Address) 626 Glenwood Ave.

15- Filed JUN 11 1922, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922, to June 10 1922, that I saw h in alive on June 9 1922, and that death occurred, on the date stated above, at 6.44A. m.

The CAUSE OF DEATH* was as follows:

Cerebro Distributal Nephritis

Chronic Mitral Insufficiency

Paralysis Agitans, Chr. Myocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. 1 mos. 2 ds.

(Signed) Geo. W. Bost M. D.

Jan 10, 191.22 (Address) 501 Shrieden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 3 mos. ds. In the State 2 yrs. 3 mos. ds.

Where was disease contracted, if not at place of death? New York

Former or usual residence Brooklyn, New York

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, June 12, 1922

20-UNDERTAKER Wilcox Cook ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be entered in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65059

CERTIFICATE OF DEATH.

58 D 65059

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 3926 Reisterstown Road WARD)

2-FULL NAME Margaret E Lessner

(a) RESIDENCE. No. 3926 Reisterstown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lessner

6 DATE OF BIRTH (month, day, and year) Sept 5 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ax Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Amanda Downes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Lessner

(Address) 3926 Reisterstown

Nov 11 1922 Robert P. Harrison, M. D. Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9-1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1919 to June 9 22

that I last saw h alive on June 9 22

and that death occurred, on the date stated above, at 11-20 P.M.

The CAUSE OF DEATH* was as follows:

Progressive Pernicious Anemia

(above date)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) D C Hawk M. D.

. 19 (Address) 1927 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	6/12 192
20 UNDERTAKER Williams Cook	ADDRESS Govr Nath

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24 14—M. & T.—2000 Bks.

D 65060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65060

159-003

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 N. Edon ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Faraone

(Residence in Baltimore—No. 1212 N. Edon St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 10 (Day), 1922 (Year)

7-AGE, ...yrs....mos....da. If LESS than 1 day, 7 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country), 1212 N. Edon St

PARENTS.

10-NAME OF FATHER, Justino Faraone

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Jennie Pistorio

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Borello

(Address) 1216 N. Central Ave

15- Robert P. Harrison,

Filed....., 191.....

Burial Permit Clerk.

Registrar.

JUN 11 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1922, to June 10 1922, that I saw him alive on June 10 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Congenital malformation of body Spina Bifida

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Benj. L. Gaden M. D.

June 11, 1922 (Address) 2306 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Vincent Cemetery

DATE OF BURIAL, June 12, 191 2

20-UNDERTAKER George F. Ruth

ADDRESS 1735 Hayford Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65061 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65061

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH Baltimore Dry Docks, Upper yard. 27 187

City of BALTIMORE: (No. Key Highway & Cross St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willian G. Larmour.

(Residence in Baltimore: No. 4505 Belmont Ave. St.; yrs. 47 mos. 3 ds. 17)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. February 22nd. 1875. (Month) (Day) (Year)

7-AGE. 47 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Robert B. Larmour.

11-BIRTHPLACE OF FATHER, (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Mary C. Grothous.

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella W. Larmour. (wife)

(Address) 4505 Belmont Ave.

15- Filed ..... 192.... Robert P. Harrison, Registrar.

11 1922 Burial Permit clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured neck.
Knocked down and rolled over by a moving crane. Accidental Death.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto F. Ernhardt M. D. (Coroner)

June 10, 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	June 12 1922
20-UNDERTAKER. J. Ullrich	ADDRESS 200 S. Exeter St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 65062

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 E. Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennette R. Rust

(a) RESIDENCE NO. 2110 E. Mounment ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Wm H. Rust

6 DATE OF BIRTH (month, day, and year): Sept 28-83

7 AGE: Years 39 Months 8 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila Pa.

PARENTS

10 NAME OF FATHER: Chas. E. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Catherine,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Wm R. Rust

(Address): 2110 E. Mounment St

15 Filed 6-11 1922, 19 Robt. P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1922 to June 7, 1922.

that I last saw h[illegible] alive on June 7, 1922,

and that death occurred, on the date stated above, at 7 25 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical & Microscopic

(Signed) Mary P. Vaeglum M. D.

6. 9, 1922 (Address) 1028 Vaeglum

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 6/12 1922

20 UNDERTAKER: Philip Herzig

ADDRESS 3016 Orleans St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 65063

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1922 Mt. Royal Terrace (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juliet Reese Bartlett

(a) RESIDENCE. No. 1922 Mt Royal St. 13 Ward. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? 67 yrs. 2 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William K. Bartlett

6 DATE OF BIRTH (month, day, and year) March 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Edw. Reese

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Filpin

13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Maryland

14 Informant (Address) Mrs. K. Bartlett - (husband) 1922 Mt Royal Terrace

15 NOV 11 1922 . 19 Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1922, to June 9, 1922, that I last saw h or alive on June 8, 1922, and that death occurred, on the date stated above, at 8.15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy.

(Signed) Grace C. Clark, M. D.

June 9, 1922 (Address) Laurel Apts. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lundis Burying Ground — DATE OF BURIAL: June 12 1922

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, MANAGER) — ADDRESS: 108 W. NORTH AVE.

N.B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia: Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar Pneumonia

Lip

D 65064 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65064

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 207 W. Mulberry St. 4 WARD.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Henry Lip

(Residence in Baltimore: No. 207 W Mulberry st. St.; 30 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Chinese

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Don't Know (Month) ..... (Day) 1 (Year)

7-AGE: 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundryman D41
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): China

PARENTS.

10-NAME OF FATHER: Don't know

11-BIRTHPLACE OF FATHER (State or Country): Chinese

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or Country): Chinese

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee Lung

(Address) 230 Park Ave

15-

Filed JUN 11 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day), 1922 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the heart

..... (Duration) ..... yrs. Don't Know mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gormley M. D. (Coroner.)

6-10-, 1922 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Dallo Cemetery DATE OF BURIAL, June 12 1922

20-UNDERTAKER: John Mitchell ADDRESS 1201 W. Fayette

Spec.—6-9-19—H. F. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65065

CERTIFICATE OF DEATH

X 44 D 65065

1-PLACE OF DEATH Union Memorial Hospital - B

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division St. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Morris M. Spiegel

(a) RESIDENCE. No. 97 Whitehall St. ST., WARD. Atlanta, Ga.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER Alexander Spiegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ernestine Ottenheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ken Spiegel
(Address) Atlanta Ga

15 Filed JUN 11 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922 to June 10, 1922, that I last saw him alive on June 10, 1922 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

General Peritonitis
on fifth day following
operation

(duration) yrs. mos. 2(?) ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. 5(?) mos. ds.

18 Where was disease contracted if not at place of death? His home

Did an operation precede death? Yes Date of June 5, '22

Was there an autopsy? Partial (Reopening incision)

What test confirmed diagnosis? Pus from abdominal cavity

(Signed) Paul W. Sutton, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Atlanta, Ga	June 11 1922

20 UNDERTAKER	ADDRESS
John O. Whitehead	120 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65066

CERTIFICATE OF DEATH.

D 65066

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5th ave. + 15th ST. 76 WARD)

2-FULL NAME William J. Carl

(a) RESIDENCE NO. 5th ave. + 15th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	70	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Carl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hanselman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Louisa Whl

(Address) 3416 Hudson St.

15 Filed JUN 11 1922, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17

I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 10, 1922,

that I last saw him alive on June 10, 1922,

and that death occurred, on the date stated above, at 9-30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

to my knowledge

(duration) yrs. mos 4 ds.

history 1 year

CONTRIBUTORY (Secondary) Pericarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isabel V. Ahern, M. D.

June 15 1922 (Address) 103 S. Potters Point

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	May 12 1922
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. B. C. Blks.

D 65067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65067

CERTIFICATE OF DEATH.

X 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 Linden Av ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Braul

(a) RESIDENCE. NO. 2317 Linden ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3-1863

7 AGE: Years 59 | Months 2 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heinrich C Braul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ottilie Knorp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Mrs Enoch P Callow

(Address) 2317 Linden Av

15 JUN 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1921, to June 9, 1922, that I last saw him alive on June 9, 1922, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Senile Myocarditis

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Hypostasis & Arteriosclerosis

(duration) — yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Chas Seltzer, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: June 12 1922

20 UNDERTAKER: Chas. E. Franck

ADDRESS: 832 Madison Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

15632

D 65068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65068

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Richard Parker

(a) RESIDENCE NO. 81 Pleasant St. ST. Annapolis Md WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ William Parker

6 DATE OF BIRTH (month, day, and year) May 22 - 75

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	47	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alethia Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 11 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to June 10, 1922, that I last saw him alive on June 10, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

Duration unknown but history dates only (duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Post-operative Shock (duration) 4 hours. ~~yrs.~~ ~~mos.~~ ~~ds.~~

18 Where was disease contracted if not at place of death? at home address.

Did an operation precede death? Yes Date of June 10, '22

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md

DATE OF BURIAL June 12 1922

20 UNDERTAKER Sam'l H. Chase & Son

ADDRESS 1400 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Jane Howes)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65069 — CERTIFICATE OF DEATH. — 46 D 65069

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp, ST., 25 WARD)

2-FULL NAME Jane Howes,

(a) RESIDENCE NO. 441 West St. Annapolis, Md ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 64 yrs. Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) " "

14 Informant Mrs. A. B. Pinit (Address) 441 West St. Annapolis

15 Filed JUN 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-17, 1922 to 6-11, 1922

that I last saw h. W alive on 6-11, 1922

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Scott, M. D.

, 19 (Address) St. Agnes Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis, Md

DATE OF BURIAL June 13 1922

20 UNDERTAKER Taylor & Sons.

ADDRESS Annapolis Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. could not determine whether cancer originated in uterus or rectum Both involved

Spec.—1-10-21—M&T—1500 Bks.

D 65070 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65070

CERTIFICATE OF DEATH.

REGISTERED NO. 98

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2532 Penna Ave ST., 15 WARD)

2-FULL NAME Ethel W. Glen

(a) RESIDENCE NO. 2532 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm R Glen

6 DATE OF BIRTH (month, day, and year) Sept 5-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work C 937

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Howard D. Grealey

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Harriett Kerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Howard F. Grealey

(Address) 2532 Penna Ave

15 FILED JUN 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from about 1st Month 1920 to June 10 1922

that I last saw her alive on June 10 1922,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart and general Anasarca from Chronic Valvular disease of heart

(duration) about 25 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pole M. D.

19 (Address) 203 Mahon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 13 1922

20 UNDERTAKER W. E. Tuckner & Son — ADDRESS North Ave

N. B. WHITE PAPER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65071

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Caster St ST.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Josephine Hackett

(a) RESIDENCE. NO. 1715 Caster St ST.. ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: 16 Years ... Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer): House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Chas A Hackett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Josephine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Charles Hackett
(Address): 1715 Caster St

15 Filed: JUN 12 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2 1922 to June 9 1922

that I last saw her alive on June 9 1922

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Phthisis

(duration) yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Contracted Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eid Hall, M. D.

, 19 (Address) 1236 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kingsville Md

DATE OF BURIAL: June 12 1922

20 UNDERTAKER: John W Henderson

ADDRESS 1601 E monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65072

D 65072

CERTIFICATE OF DEATH.

REGISTERED NO. 135

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2725 Parkwood Ave (ST.) 13 (WARD)

2-FULL NAME John Francis Cecil

(a) RESIDENCE: No. 2725 Parkwood Ave (ST.) 13 (WARD)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Delia Cecil

6 DATE OF BIRTH (month, day, and year) Jan. 28. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor and Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Leonardtown St Marys Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant (Address) Margaret D Cecil 2725 Parkwood ave

15 Filed JUN 12 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to June 9, 1922, that I last saw him alive on June 9 1922 and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) J. Fleming Gardner M. D.

, 19 (Address) 2731 Parkwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 13 1922

20 UNDERTAKER ADDRESS

Josiah Bayless 600 N Howard St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65073

CERTIFICATE OF DEATH.

X 31

D 65073

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 1219 E. North ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence C. Toole.

1 wk.

(Residence in Baltimore: No. 1219 E. North ave St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 25, 1863
(Month) (Day) (Year)

7-AGE, 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Supt.

9-BIRTHPLACE, (State or Country), Newark. New Jersey

PARENTS.

10-NAME OF FATHER, John Toole

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Welsh

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Deegan

(Address) 1219 E. North ave

15-

Filed ..... 191.....

ROBERT R. KNAUTER, Burial Permit Clerk.

JUN 12 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1922, to June 11 1922, that I saw him alive on June 11 1922, and that death occurred, on the date stated above, at 9.20 p m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 12 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Phthisis

(Duration) 12 yrs. ..... mos. ..... ds.

(Signed) C. P. Cannan M. D.

6-1-1922, 191.2. (Address) 1201 N. Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Catholic Par

DATE OF BURIAL, June 12, 1922

20-UNDERTAKER Richard F. Curley

ADDRESS 438 E. North ave

Spec.—1-10-21—M&T—1500 Bks.

65074 HEALTH DEPARTMENT—CITY OF BALTIMORE, OD 65074

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 Augusta Ave. WARD 20)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine McHugh

(a) RESIDENCE NO. 731 Augusta Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed~~, or divorced ~~HUSBAND~~ of (or) WIFE of: Lawrence McHugh

6 DATE OF BIRTH (month, day, and year): Dec 24 1857

7 AGE: Years 65 Months 5 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 237

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thos. Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary McHugh (Address) 731 Augusta Ave

15 Filed JUN 12 1922 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9 19 22

17

I HEREBY CERTIFY, That I attended deceased from Jan 17, 19 22 to June 9, 19 22

that I last saw h[illegible] alive on June 8, 19 22,

and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Standish McLaughlin M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 12 19 22

20 UNDERTAKER: Margaret G. Flynn — ADDRESS: 1 [illegible] Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65075

CERTIFICATE OF DEATH.

3/D 65075

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1405 Race (St.:) 23 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie North

(a) RESIDENCE. No. 1405 Race St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 18/1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert North

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nellie Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Wm J. Edmonson 1725 Clendon

15 Filed JUN 12 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to June 10, 1922, that I last saw h alive on June 10, 1922, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R E L Campbell M. D.

June 10, 1922 (Address) 1644 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patricks Cemetery

DATE OF BURIAL 6/13 1922

20 UNDERTAKER William Cook

ADDRESS 502 S Nov

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65076

D 65076

CERTIFICATE OF DEATH.

REGISTERED NO. 4 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Gray

(a) RESIDENCE. NO. 3 E. pleasant st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Welsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M.T.H.

15 Filed JUN 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to June 10, 1922, that I last saw him alive on June 10, 1922, and that death occurred, on the date stated above, at 10:50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) Francis L. Dalaglisch, M. D.

6-11 1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lyon A.A. Co.	June 1922

20 UNDERTAKER ADDRESS

William Cook 5026 Nall Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65077

HEALTH DEPARTMENT—CITY OF BALTIMORE, 801 D 65077

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807. N Calvert ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Stubler

(Residence in Baltimore: No. 807. N Calvert St.; Life yrs. ..... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, June (Month) 10 (Day), 1922 (Year)

7-AGE, a few minutes yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Stubler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Cecilia Rodgers

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles J. Stubler

(Address) 807 N. Calvert St.

15-

Filed JUN 12 1922 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1922, to June 10th 1922, that I saw him alive on June 10th 1922, and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Premature birth - about 6 mths Utero gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. W. Keown M. D.

June 10, 1922 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, 6/12, ..., 1922

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65078

CERTIFICATE OF DEATH.

101 B 65078

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 101 Edgevale Road (St.) 27 (Ward)

2-FULL NAME Martha Woodward Phelps

(a) RESIDENCE. No. 101 Edgevale Road St., Ward. Native

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~Husband of~~ Wife of Charles Edward Phelps

6 DATE OF BIRTH (month, day, and year) 29 Jan 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	(84) 8~~4~~	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ~~Nil~~

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ ~~Nil~~

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Princeville, Dan Prince Co Va

12 MAIDEN NAME OF MOTHER Virginia Barnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Woodward Phelps

(Address) 101 Edgevale Rd.

15 Filed JUN 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1917, to June 10, 1922,

that I last saw h alive on June 1, 1922,

and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Primary)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 3+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. ~~L~~ Fowler, M. D.

(Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn — DATE OF BURIAL June 12 1922

20 UNDERTAKER Henry H Jenkins Son Co — ADDRESS Orchard Mc Culloh

THIS CERTIFICATE should be filled out, signed and mailed to the Registrar of the district in which death occurred, as soon as possible after death. FACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65079

D 65079

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 411 Streeper St., 6 WARD)

2-FULL NAME William H. Kraft

(a) RESIDENCE NO. 411 Streeper ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kraft

6 DATE OF BIRTH (month, day, and year) July 14, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer Bethlehem Steel Co. Balto Md.

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Kraft

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary R. Snyder

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mary Kraft

(Address) 411 Streeper St

15 Filed JUN 12 1922 ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to June 10, 1922,

that I last saw h— alive on June 9, 1922

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

(Carcinoma, ? Tonsil)

Hemorrhage (Int. Jugular)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma Tonsil

..... (duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) Buckel, M. D.

, 19 (Address) 100 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 12 1922
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Pleasant St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65080

CERTIFICATE OF DEATH.

80 D 65080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 S. Montford Ave ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Rychalski

(Residence in Baltimore: No. 817 S. Montford Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. April (Month) 26 (Day), 1919 (Year).

7-AGE, 3 yrs. 1 mos. 14 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md -

PARENTS.

10-NAME OF FATHER, Jos. Rychalski

11-BIRTHPLACE OF FATHER (State or Country), Balto Md -

12-MAIDEN NAME OF MOTHER Mary Kaszak

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Rychalski

(Address) 817 S. Montford Ave

15- JUN 12 1922. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 10 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to June 10 1922, that I saw him alive on ..... 9 1922, and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. O. Nee M. D.

6/10/22, 191... (Address) 1108 E. Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. St Stanislaus Cem. DATE OF BURIAL, June 12 1922

20-UNDERTAKER Stephen Hackarski ADDRESS 1108 E Monument Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Cause of convulsions unknown. Probably due to something child had eaten. What food

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6508I

100-001

D 6508I

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N. Belair Road ST., Parkhurst WARD)

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ellis Rasp

(a) RESIDENCE NO. 515 N. Belair Road ST., Parkhurst WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 29th 1921

7 AGE — Years: — Months: 11 Days: 11 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — ood

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: Charles Wm Rasp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Jennie Tull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greenwood Delaware

14 Informant: Charles Wm Rasp

(Address): Raspburg Md.

15 JUN 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1922, to June 10, 1922, that I last saw him alive on June 10, 1922, and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis with Emphysema of Lungs (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Webster M. D.

, 19 (Address) 103 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jerusalem Cemetery — DATE OF BURIAL: Jun 13 22

20 UNDERTAKER: Frederick Lorsch & Sons — ADDRESS: Fulbeltore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65082

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 65082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1610 Lancaster St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Winiecki

(Residence in Baltimore: No. 1610 Lancaster St.; 36 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)

7-AGE, About 61 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer): 074

9-BIRTHPLACE, (State or Country) Poland

PARENTS.

10-NAME OF FATHER B. Winiecki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Winiecki

(Address) 1610 Lancaster St.

15-Filed JUN 12 1922, 401

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchial Asthma

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

June 10, 1922 (Address) Curtis Bay Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, June 13, 1922.

20-UNDERTAKER W. F. Sadowski ADDRESS 708 S. Ann St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 179 D 65083

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 7

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Sharpsin

(a) RESIDENCE No. 5825 Catherine St Phila Pa WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Male~~ ~~Female~~ male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Rebecca Sharpsin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	×	×	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harris Sharpsin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed JUN 12 1922 ROBERT R. KRAUTER, Registrar.

JUN 12 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to June 11, 1922, that I last saw him alive on June 8, 1922, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

nephritis uremia.

(duration) ... yrs. 6 mos + ds.

CONTRIBUTORY (Secondary) prostatic hypertrophy

(duration) 1 yrs. + mos. + ds.

18 Where was disease contracted if not at place of death? Philadelphia Pa

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? phthalein & blood urea

(Signed) J. L. Houghton M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa — DATE OF BURIAL Jun 13 1922

20 UNDERTAKER Joseph Abrens — ADDRESS 221 N Bro...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 65084

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) 3 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Davis

(a) RESIDENCE. No. 1415 Eastern ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Umbrella repairer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: F. Asbury Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Susan Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed JUN 12 1922 . 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to June 10, 1922, that I last saw him alive on June 10, 1922, and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglisee M. D.

6-10-22 . 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	June 13 22
20 UNDERTAKER J. Ullrich	ADDRESS 2008 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

74 D 65085

65085 D

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Mosher ST. 16 WARD)

2-FULL NAME Lena R. Scott

(a) RESIDENCE NO. 1418 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Scott

6 DATE OF BIRTH (month, day, and year): Autumn, 1874

7 AGE: Years 48 | Months - | Days - | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Petersburg Va

PARENTS

10 NAME OF FATHER: Anderson Lindy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Autoon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Laonne Jackson (Address) 1418 Mosher St

15 Filed JUN 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922 to June 9, 1922.

that I last saw h[illegible] alive on June 9, 1922

and that death occurred, on the date stated above, at 2:25 P m.

The CAUSE OF DEATH* was as follows:

apoplexy

Asthma Dropsy + Parical Paralysis (duration) yrs. / mos 2 ds.

CONTRIBUTORY (Secondary) asthma + dropsy (duration) yrs. / mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. W. Kennard, M. D.

6-10 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: June 12 22

20 UNDERTAKER: Samuel Hensley

ADDRESS: 37 Bell St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Seitz) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

65086 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65086

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2265 W. Baltimore ST. 20 WARD)

2-FULL NAME Augusta Seitz

(a) RESIDENCE. NO. 2265 W Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Husband~~ Henry Seitz

6 DATE OF BIRTH (month, day, and year) Oct 1-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Frank Grunewood (Address) 2265 W Baltimore St

15 Filed JUN 12 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1- 1922 to June 9- 1922 that I last saw her alive on June 8 1922 and that death occurred, on the date stated above, at 11.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E Heller Hemming M. D.

6/9. 1922 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 12 1922

20 UNDERTAKER ADDRESS

H. B. Hupfeld 2236 Frederick Ave

---

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65087

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " ST., 17 WARD)

2-FULL NAME Glentor Brooks.

(a) RESIDENCE NO. 711 Brune St. City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced (HUSBAND of) (or) (WIFE of): Evelyn Brooks mother

6 DATE OF BIRTH (month, day, and year): Feb 23 1922

7 AGE: Years — Months 3. Days 18. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child, Col'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Avon Brooks,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Evelyn Minor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records.

15 Date: JUN 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9. 1922 to June 10. 1922 that I last saw h[illegible] alive on June 10. 1922 and that death occurred, on the date stated above, at 11 00 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Malnutrition —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None -

(Signed) Horace L. Stewart, M. D.

6/10. 1922 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery DATE OF BURIAL June 1922

20 UNDERTAKER: Jas. Geo. H. Hofer ADDRESS 40 & McCulloh

Burial Permit Clerk.

Burial permit should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65088 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 65088

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3712 Chestnut Rd St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and nnmber and fill out No. 18.)

2-FULL NAME Jos. Ley Biden

(Residence in Baltimore: No. 3712 Chestnut Rd St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	widower

6-DATE OF BIRTH. Dec. 31 1863 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
58 yrs. 5 mos. 8 ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Jo. Biden

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Co. Md.

12-MAIDEN NAME OF MOTHER. Lydia Randle

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Randle L. Biden

(Address) 1214 Dukeland St.

15- Filed JUN 12 1922 J. E. Wehn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 1 yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 12 1922 (Address) 2803 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Cemetery	6/12 1922

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65089

CERTIFICATE OF DEATH.

58/D 65089

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5423 Park Heights Avenue ST.; 27 WARD)

2-FULL NAME Michael Wm Mullen.

(a) RESIDENCE. No. 5423 Park Heights Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen F. Trainor

6 DATE OF BIRTH (month, day, and year): Jan. 17, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturer's Agent

(b) General nature of industry, business, or establishment in which employed (or employer): Gas Water Heaters

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dinsmore, Pa.

PARENTS

10 NAME OF FATHER: John Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Skarry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Helen F. Mullen
(Address): 5423 Park Heights Avenue

15 Filed ..., 19.. Registrar

JUN 12 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb'y, 1922, to June 11, 1922, that I last saw h.. alive on June 11, 1922, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Nervous Anemia.

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Pk Hts ave.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Wm H Lowe M.D. M. D.

6/11/22. (Address) Arlington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/13, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec.—5-19-13—M. & T.—500 Bks.

D 65090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65090

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hayward Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred O Whitehorn

(Residence in Baltimore: No. 3508 Fairview Ave St.; 1 yrs., 6 mos. ds.)
Forest Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, June (Month) 10 (Day), 1855 (Year)

7-AGE, 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Coal

9-BIRTHPLACE, (State or Country), Canada

PARENTS.

10-NAME OF FATHER, Samuel Whitehorn

11-BIRTHPLACE OF FATHER (State or Country), Canada

12-MAIDEN NAME OF MOTHER Mary Frazer

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Fouche

(Address) 126 N. Calhoun St

15- JUN 12 1922 Filed, 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to June 11 1922 that I saw him alive on June 11 1922, and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Heuer H. Condon M. D.

191.. (Address) 750 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 3508 Fairview Ave

Former or usual residence Usual Residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, June 13, 1922

20-UNDERTAKER George J Smith

ADDRESS Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65091 D 65091

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Arnett

(a) RESIDENCE NO. 2227 Guilford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-11-22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	×	×	×	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md

PARENTS

10 NAME OF FATHER Harry Arnett

11 BIRTHPLACE OF FATHER (city or town) Balto, Md (State or country)

12 MAIDEN NAME OF MOTHER Margaret Wilson

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md (State or country)

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 12 1922 ROBERT R. KRAUTER. Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1922

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to June 11, 1922

that I last saw him alive on June 11, 1922

and that death occurred, on the date stated above, at 1 50/60 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 2 hrs - ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Weight - 3 lbs. 16½ oz.

(Signed) Horace G. Stewart, M. D.

6/12, 1922 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents — DATE OF BURIAL June 12 1922

20 UNDERTAKER Leo G. Cook — ADDRESS Northumberland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65092

CERTIFICATE OF DEATH.

31 D 65092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 232 N. Caroline ST., 5 WARD)

2-FULL NAME Richard Geo Shipley

(a) RESIDENCE NO. 232 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 30 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Patrick Shipley

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary Crowley

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Jno. C. Shipley
(Address) 232 N Caroline

15 Filed JUN 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 8, 1922.

that I last saw him alive on June 7, 1922.

and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Laryngeal Intoxication

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Emory M. D.

6/9, 1922 (Address) 432 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Harford Co. DATE OF BURIAL June 12 1922

20 UNDERTAKER Leo G. Cook ADDRESS North Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and the

Spec.—6-9-19—H. P. Co.—1000 Bks.

Juskiewicz ✓ D 65093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65093

CERTIFICATE OF DEATH.

156

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emelia Juskiewicz

(a) RESIDENCE. NO. 417 S Paca ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Vincent Juskiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Antanina Kasparaviciute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

11 Informant (Address) Hospital Records

15 Filed JUN 12 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922, to June 10, 1922

that I last saw h(er) alive on June 10, 1922

and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Multiple Osteo-myelitis (Pelvis Bones-) (left Femur & left Tibia.)

(duration) yrs. 1 mos. 29 ds.

CONTRIBUTORY (Secondary) General Septicemia

(duration) yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? 417 S. Paca St.

Did an operation precede death? Yes Date of 4/14/22, 4/22/22, 4/28/22, 5/5/22

Was there an autopsy? No

What test confirmed diagnosis? X-ray, operation & Lab.

(Signed) L. B. Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 13 1922
20 UNDERTAKER	ADDRESS
John Gobliauckas	425 S. Paca St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
history of
No injury.
Septic infection.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65094

D 65094

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 E. Lombard ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Maria Matey

(a) RESIDENCE NO. 1826 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Matey.

6 DATE OF BIRTH (month, day, and year) March 23-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home. 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER August Olschewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John J. Matey 1826 E. Lombard St.

15 Filed JUN 12 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to June 10, 1922.

that I last saw h alive on June 10, 1922

and that death occurred, on the date stated above, at 4.40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo. Heller, M. D.

6/12 1922 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL June 13 1922

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 N. Wolfe

ATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65095

CERTIFICATE OF DEATH.

31 D 65095

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 910 W. Fayette (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Taylor.

(a) RESIDENCE. (No.) 910 W. Fayette (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abram H. Taylor.

6 DATE OF BIRTH (month, day, and year): Jan. 20 - 1873

7 AGE — Years: 49 — Months: 4 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General natare of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Grey.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Murphy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Mystle Taylor Jewell

(Address): 910 W. Fayette St.

15 Filed ....., 19 .....

Robert F. Harrison, Registrar

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11th 1922

17

I HEREBY CERTIFY, That I attended deceased from 4-1-, 1921, to June 11, 1922

that I last saw her alive on June 10, 1922,

and that death occurred, on the date stated above, at 8½° A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Riland, M. D.

6-11, 1922 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 13th 1922

20 UNDERTAKER: Mr & Mrs John W. Tenfel & Son — ADDRESS: 801 W. Fayette St

D 65096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65096

CERTIFICATE OF DEATH.

1 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Low~~ Fayette Florles St. 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Anderson

(Residence in Baltimore: No. ~~Douglas~~ Front 200 Cobins St.; yrs., mos. ds.) 5

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov. 3, 1877
(Month) (Day) (Year)

7-AGE, 45 yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Hotel man
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Alexandria Va

PARENTS.

10-NAME OF FATHER, Henry Anderson

11-BIRTHPLACE OF FATHER (State or Country) Alexandria

12-MAIDEN NAME OF MOTHER ~~Mary~~

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Anderson

(Address) 20 S. Colvin St.

15-

Filed....., 191.....

Registrar.

UN 12 1922

Robert P. Harrison.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart
Carcinoma
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Edema
(Duration) ....yrs....mos....ds.

(Signed) ..... M. D.
(Coroner.)

June 12 1922. (Address) 1057 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. 1/2 hour yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Washington D.C. DATE OF BURIAL, June 12 22

20-UNDERTAKER Samuel Kennedy ADDRESS 528 N Eden St

(1)—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65097 D 65097

CERTIFICATE OF DEATH.

REGISTERED NO. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3325 Fremont Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vida Perry Avery

(a) RESIDENCE NO. 3325 Fremont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Benjamin B. Avery

6 DATE OF BIRTH (month, day, and year) 12/17/1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pulaski Co. Ga

PARENTS

10 NAME OF FATHER Albert Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pulaski Co Ga

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pulaski Co

14 Informant Husband. (Address) Benj. Avery.

15 1922 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1922

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1922 to June 11, 1922, that I last saw her alive on June 10, 1922 and that death occurred, on the date stated above, at 10.45A, m.

The CAUSE OF DEATH* was as follows:

Cancroma Uteres

Dont Know.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) J. J. Costello, M. D.

, 19 (Address) 335 E 31st St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cochran, Ga

DATE OF BURIAL June 13 1922

20 UNDERTAKER George F. Ruth

ADDRESS 1735 Hayford Ave

BEFORE SIGNING BE CAREFULLY ASSURED AGE should be Stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N1

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65098

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 65098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Ihmsby court 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Franca Wells

(a) RESIDENCE No. 102 Ihmsby court ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922 april 28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) 102 Ihmsby Court

PARENTS

10 NAME OF FATHER Wilber Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Catherine J Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Sadie J Johnson
(Address) 102 Ihmsby Court

15 Filed . 19 ROBERT R. KRAUTER Registrar
JUN 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30 1922 to June 12 1922,
that I last saw h in alive on June 11, 1922,
and that death occurred, on the date stated above, at 4 00 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis
and Ileocolitis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) Fred Stalle, M. D.

. 19 (Address) 426 E 23 ds

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Rest Cem — DATE OF BURIAL: June 13 1922

20 UNDERTAKER: J Stu Burns Sons — ADDRESS: Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Egll)

D 65099 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65099

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 w. Franklin ST., 18 WARD)

2-FULL NAME George. P. Egll

(a) RESIDENCE NO. 1133 w. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa A. Egll

6 DATE OF BIRTH (month, day, and year): July 27 1846

7 AGE — Years: 75 Months: 11 Days: 17 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Philip. Egll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dick Krouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: A. R. Conrad

(Address): 1133 w. Franklin st

15 Filed JUN 13 1922 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from — , 19 10 , to June 10 , 1922 ,

that I last saw him alive on June 9 , 1922 ,

and that death occurred, on the date stated above, at 4 45 m.

The CAUSE OF DEATH* was as follows:

Acute diffuse nephritis

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Valvular heart disease, arterial sclerosis

Interstitial nephritis (duration) 12 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine, physical exam.

(Signed) Geo. T. Kemp , M. D.

Jun 13, 1922 (Address) St James Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: June 13 1922

20 UNDERTAKER: for. Joseph Lord — ADDRESS: 2178 Pa Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65100

CERTIFICATE OF DEATH.

9 D 65100

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1348 Carroll — ST., 21 WARD)

2-FULL NAME Sarah Hopkins

(a) RESIDENCE No. 1348 Carroll Av ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 1-1920

7 AGE — Years: 1 — Months: 9 — Days: ..... — If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nonepod

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Landon Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Esther Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: David Taylor

(Address): 916 Barney

15 Filed JUN 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-11- 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-10- , 1922, to 6-11- , 1922, that I last saw h alive on 6-11- , 1922 and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) ..... yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Stephen A Dorsey, M. D.

, 19 (Address) 227 Columbia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: June 13 1922

20 UNDERTAKER: David Taylor — ADDRESS 916 Pa Av

IMPORTANT. This certificate should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

127 D 65101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 683 Vine (St.) 4 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Scott

(a) RESIDENCE. No. 683 Vine St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Scott

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Alice Dashiell

(Address) 663 Vine St.

15 Filed JUN 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1922

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1922, to June 10 Th. 1922, that I last saw him alive on June 2 Th. 1922, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cholitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. B. Evans, M. D.

, 19 (Address) 411 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jun 13 1922
20 UNDERTAKER Daniel Easton	ADDRESS 911 Pine

INFORMANT SHOULD BE CAREFULLY ADVISED. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65102 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65102

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 746 W Mulberry ST., 17 WARD)

2-FULL NAME Maggie Gough

(a) RESIDENCE NO. 746 Mulberry St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8-27-87 8-27-87

7 AGE: Years 34 Months 9 Days 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER Frank Gough

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. City

12 MAIDEN NAME OF MOTHER Lucy Brunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant (Address): Edward M. Gough Jr. 73 Dolphin St

15 Filed JUN 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 19 22, to June 12th 1922, that I last saw h alive on June 12th 1922, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(Duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Operations for ruptured Appendix (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Gibbs M. D.

(Address) 6/12/1922 1724 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: June 14 1922

20 UNDERTAKER: Sam'l M. Chase & Son ADDRESS: 1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65103

CERTIFICATE OF DEATH.

74 D 65103

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Walbrook Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Hyde

(a) RESIDENCE. No. 3400 Walbrook Ave ST. 15 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? 86 yrs. 2 mos. 8 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 3 1836

7 AGE — Years: 86 — Months: 2 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Anthony Hyde

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rothmoor Germany

12 MAIDEN NAME OF MOTHER: Margaret Radmuhff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rothmoor Germany

14 Informant (Address): Mrs Josephine E. Smith Catonsville Md 3406 Walbrook Ave

15 Filed JUN 13 1922 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 1922 to June 11 1922

that I last saw h alive on June 11 1922

and that death occurred, on the date stated above, at 1. P. — m.

The CAUSE OF DEATH* was as follows:

Senile myocarditis and arteriosclerosis

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Hemiplegia (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Harvey Cole M. D.

19 (Address) 2202 Gwynn Oak Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery DATE OF BURIAL: June 13/22

20 UNDERTAKER: [illegible] & MOWEN COMPANY (WILLIAM F. MO[illegible]) ADDRESS: [illegible] NORTH AVE.

D 65104

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 65104

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 147 N. East St ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Wallace

(Residence in Baltimore: No. 147 N. East St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown 1 (Month) (Day) (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Conrad Davis

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary Sullivan

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice Wallace

(Address) 147 East st

15-

Filed JUN 13 1922 191.. ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

Duration

CONTRIBUTORY (Secondary)

(Duration)

(Signed) W. S. Riley M. D. (Coroner.)

June 11, 1922. (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bay View cemetery

DATE OF BURIAL, June 13, 1922.

20-UNDERTAKER Edward Beyer

ADDRESS 1631 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65105

CERTIFICATE OF DEATH.

qf D 65105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Maryland Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Gertrude Wisner

(a) RESIDENCE. No. 2125 Maryland Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. J. Ward Wisner

6 DATE OF BIRTH (month, day, and year) Jan. 26" 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 007

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manassas Virginia

PARENTS

10 NAME OF FATHER Alexander H. Roseberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Sarah C. Wolverton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Dr. J. Ward Wisner
(Address) 2125 Maryland Ave.

15 Filed JUN 13 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to June 12, 1922, that I last saw h[illegible] alive on June 1, 1922, and that death occurred, on the date stated above, at 5.05 A m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolus

Sudden (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Backyard

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Delaney Thomas, M. D.

June 12, 1922 (Address) 330 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 14 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Ballo St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 65106 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 001 D 65106

CERTIFICATE OF DEATH.

14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Olive ST.: 23 WARD)

2-FULL NAME Louise Taylor

(a) RESIDENCE. No. 1120 Olive ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name of Hospital or Institution should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benj. Taylor.

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 73 Months 7 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ——

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Earl Brown (Address) 846 S Sharp St.

15 Filed JUN 13 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/7/ 1922, to 6/9/ 1922, that I last saw h alive on 6/9/ 1922, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Sen. Acute Interstitial Nephritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Microscopical Exam

(Signed) Dan Buxley, M. D.

6/12/ 1922 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	June 13 1922
20 UNDERTAKER John H Toadvine	ADDRESS 147 Wash Blvd

D 65107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65107

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1505 E Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Jones

(Residence in Baltimore: No. 1505 E Monument St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1..... (Year)

7-AGE 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Prince Georges Co Md

PARENTS.

10-NAME OF FATHER, John Jones

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Puckum

13-BIRTHPLACE OF MOTHER, (State or Country) Prince Geo Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Half-Sister

(Address) 1505 E Monument

15-

Filed JUN 13 1922 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day), 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Pollitt M. D.
(Coroner.)

June 13 192.2 (Address) 5 0 8 E North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel — DATE OF BURIAL, June 13 1922

20-UNDERTAKER, John E Henderson — ADDRESS 1502 E Monument

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65108

CERTIFICATE OF DEATH.

✓ 002

159 D 65108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 Boone St. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Collins Hood

(a) RESIDENCE. No. 2106 Boone St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Hood

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Elizabeth Collins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Charles Hood
(Address) 2106 Boone St.

15 Filed JUN 13 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from September, 1920, to June 11, 1922, that I last saw h[illegible] alive on June 9, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Congenital malformation of heart

(duration) 10 yrs. 11 mos. 16 ds.

18 Where was disease contracted if not at place of death? congenital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. Charles Smith 2nd, M. D.

(Address) Sevem Apts - Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 14 1922

20 UNDERTAKER E. R. Wedefeldt ADDRESS 501 E 22 St

D 65109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1942 D 65109

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Calvin Johnson. (C)

(Residence in Baltimore: No. 127 W. Hill St. St.; yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. July 26th. 1889. (Month) (Day) (Year)

7-AGE. 32 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Coal passer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... D 74

9-BIRTHPLACE, (State or Country). Tennasee.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Smith. (C)

(Address) 127 W. Hill St.

15-

Filed JUN 13 1922 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9th. 1922. (Month) (Day) (Year) 19..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat brostration.

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

June 13. 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	6/13/22 19..
20-UNDERTAKER	ADDRESS
R. J. Parham	1220 W. Hamburg

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90. D 65110

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2619 Fait ave. St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Lemieck

(a) RESIDENCE. NO. 2619 Fait ave St., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. — mos. — ds. How long in U. S., if of foreign birth? 31 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL items of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Mar. 22-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Ana Tadajewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: John Lemieck
(Address): 2619 Fait Av.

15 Filed JUN 13 1922

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to June 12, 1922, that I last saw h alive on June 11, 1922, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. J. McAvoy, M. D.

June 13 1922 (Address) 2319 E. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebron Cemetery	June 14 1922
20 UNDERTAKER	ADDRESS
Wood & Kenwood Ave	1018 Kenwood Ave
St. Stanislaus Cem.	

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65111

CERTIFICATE OF DEATH.

101 D 65111

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Greenway Apts. Charles & 34th Sts. WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Campbell Reynolds

(a) RESIDENCE. No. Greenway Apts. Charles & 34th. Sts. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. Geo. B. Reynolds

6 DATE OF BIRTH (month, day, and year): Mar 4, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Washington D. C.

PARENTS

10 NAME OF FATHER: Charles B. Fiske

11 BIRTHPLACE OF FATHER (city or town) (State or country): Connecticut

12 MAIDEN NAME OF MOTHER: Mary Elizabeth Bender

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D. C.

14 Informant: Stanley M. Reynolds
(Address): 227 W. Lanvale Street

15 Filed JUN 13 1922 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17th, 1922, to June 11th, 1922, that I last saw h[illegible] alive on June 11th, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Abscess of Lung

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. F. Loellenbach M. D.

19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6/14. 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Due to pneumonia

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65112

CERTIFICATE OF DEATH.

32 D 65112

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Bloom St., 14 WARD)

2-FULL NAME Beatrice Shange

(a) RESIDENCE NO. 505 Bloom St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12, 1912

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
10	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of Industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Walter Shange

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Marion Weston

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Carolina

14 Informant Marion Shange

(Address) 505 Bloom St

15 Filed JUN 13 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/9, 1922, to 6/12, 1922, that I last saw h[illegible] alive on 6/12 6, 1922, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) 2139 Dr. Ln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL June 14 1922

20 UNDERTAKER Clarence E. Wright ADDRESS 1367 McCay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Of Tuberculous origin. Not epidemic

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65113

D 65113

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp (ST.) 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Auld

(a) RESIDENCE NO. 3027 McElderay ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?-Feb 9-1878

7 AGE: Years 44 | Months 4 | Days 5 | If LESS than 1 day, ...hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 609

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer C. H. Pritchett

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Auld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant.. Sarah Auld

(Address) 3027 Nor. E. Elderay St

15 Filed JUN 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 12, 1922, that I last saw him alive on June 12, 1922, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S. & P. S. - Blood Urea

(Signed) J. V. Bozerlichi, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: June 14 1922

20 UNDERTAKER: Jno R. Miller

ADDRESS 2334 Jefferson St

Spec.—1-10-21—M&T—1500 Bks.

D 65114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 65114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 19 WARD)

2-FULL NAME Frank Warfield

(a) RESIDENCE NO. 524 Parrish St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1858 or 66?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55 or 63		--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard Co., Maryland

PARENTS

10 NAME OF FATHER: James Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co., Maryland

12 MAIDEN NAME OF MOTHER: Harriet Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Maryland

14 Informant: Hospital Records,

(Address) Municipal Hospital.

15 Filed JUN 13 1922 Registrar A. Jones

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1922

17

I HEREBY CERTIFY, That I attended deceased from May 24 1922 to June 11 1922,

that I last saw him alive on June 11 1922,

and that death occurred, on the date stated above, at 3:55 P.M.

The CAUSE OF DEATH* was as follows:

Tabes dorsalis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. / mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Clyde M. Neil, M. D.

6/12/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: June 14 1922

20 UNDERTAKER: A. Jones ADDRESS: 207 S Stricker St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilitic.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65115 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 65115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 250 N. Bruce ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Claggett

(Residence in Baltimore: No. 250 N. Bruce St.; 5 yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F. | 4-COLOR OR RACE. Col | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 42 yrs. — mos. — ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Leonard Atkenson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Leona Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leona Anderson

(Address) 29 N. Vincent St

15-

Filed JUN 13 1922 191... ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1922, to June 10 1922, that I saw her alive on June 10 1922, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Asthma

(Duration)....yrs....mos....ds.

(Signed) Henry H. Weinberger M. D.

June 12, 1922 (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem | DATE OF BURIAL, June 13th 1922

20-UNDERTAKER A. Jones | ADDRESS 247 S Stricker St

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Yanovich)

D 65116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65116

CERTIFICATE OF DEATH

45

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dusan Jovanovich

(a) RESIDENCE. No. 1268 Glyndon ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Jessa Jovanovich

6 DATE OF BIRTH (month, day, and year): — — 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Serbia

PARENTS

10 NAME OF FATHER: — Jovanovich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Serbia

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant (Address): University Records

15 JUN 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-13- 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1 — 1922, to June 13 1922, that I last saw him alive on June 13 - 22 19, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-2-22

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) J. R. O'Rourke, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 15th 1922
20 UNDERTAKER	ADDRESS
A. Jones	207 S. Shucker st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospitals 3 REGISTERED NO. 74

CITY OF BALTIMORE: (No.) ..... ST.; (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenny Bean

(a) RESIDENCE. No. 1412 Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Born in Balto City 10 yrs

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Hosp Records

15 Filed JUN 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-8-1922 to 6-11-1922 that I last saw him alive on June 10. 1922 and that death occurred, on the date stated above, at 8.40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Aut

(Signed) Clyde McNeill, M. D.

6/13, 19 (Address) Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: June 13th 1922

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 172 Robert Lane

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65118

CERTIFICATE OF DEATH.

90 D 65118

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2227 Sherwood Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Mender

(Residence in Baltimore: No. 2227 Sherwood Ave St.; yrs., 21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH, Dec 3, 1861
(Month) (Day) (Year)

7-AGE, 61 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Brewer
(b) General nature of industry, business, or establishment in which employed (or employer) 88

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Mender

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Wilhelmina

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mender wife

(Address) 2227 Sherwood Ave

15-

Filed JUN 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Lesion

.....(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) J. H. Pallen

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Pallen M. D.
(Coroner.)

June 13 1922 (Address) 108 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery DATE OF BURIAL, June 13, 1922

20-UNDERTAKER George J Ruth ADDRESS 1735 Harford Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65119

CERTIFICATE OF DEATH.

002 161 D 65119

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 N. Fulton Ave. ST. 15 WARD)

2-FULL NAME Kirikos Busku

(a) RESIDENCE. NO. 2203 N. Fulton Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6-12-22

7 AGE — Years | Months | Days | If LESS than 1 day, 3 hrs. or ~~1~~ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): Baby

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Kirikos Busku

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Evangelia Papadopoulos

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: John Busku
(Address) 2203 N. Fulton ave

15 JUN 13 1922 ROBERT R. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6.12. 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 12, 1922,
that I last saw h[illegible] alive on June 12, 1922,
and that death occurred, on the date stated above, at 7.30 m.
The CAUSE OF DEATH* was as follows:

Gastritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. V. Mann, M. D.

6.13. 1922 (Address) 801 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: 6/13 1922

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun [illegible]

D 65120

D 65120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Covington St., (Key Highway) 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Orville W. Crockett.

(Residence in Baltimore: No.....629 E. Clement St.....St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. August 10th. 1913.
(Month) (Day) (Year)

7-AGE. 8 yrs. 10 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. John W. Crockett.

11-BIRTHPLACE OF FATHER, (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER. Cora A. Atlein.

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Crockett. (father)

(Address) 629 E. Clement St.

15- JUN 13 1922 192. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Missing June 10, 1922
Body found June 12th. 1922., 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a wharf while at play. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)
June 13th 192. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	June 13 192.

20-UNDERTAKER	ADDRESS
Wm. J. Lee & Son	1438 Park Ave.

Frank

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65121

CERTIFICATE OF DEATH.

161 D 65121

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S. Clinton St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonnina Blonisio

(Residence in Baltimore: No. 209 S Clinton St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 4 (Day), 1922 (Year)

7-AGE, ...yrs....mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) 00

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Salvatore Blonisio

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Anna Lynna

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Blonisio

(Address) 209 S. Clinton St

15-

Filed....., 191.... L. L. .....

JUN 13 1922 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1921 to June 12 1922, that I saw h[illegible] alive on June 5 1922 and that death occurred, on the date stated above, at 1650 m.

The CAUSE OF DEATH* was as follows:

Pneumonia both lungs

Broncho Pneumonia (Sinus)

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.

June 13, 1922 (Address) 1036 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart

DATE OF BURIAL, June 13, 1922

20-UNDERTAKER Kelly & Zeiler

ADDRESS 403 S. Wolfe St

CAUSE OF DEATH must be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65122 Union D 65122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 428 W. Conway St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Petrila

(Residence in Baltimore: No. 428 Conway St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Don't Know (Month) (Day) (Year)

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Joseph Petrila

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Mary Krevcunas

13-BIRTHPLACE OF MOTHER, (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Baranckene

(Address) 716 W. Lombard St.

15- Filed JUN 13 1922 192 Robert P. Harrison, Registrar.

Burial Permit Clerk's Name

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy~~ or Inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ ~~topsy or~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) W. H. Forney M. D. (Coroner.)

6-13 1922 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, June 14 1922

20-UNDERTAKER, John Grebinskas — ADDRESS 425 S. Paca St.

N. B.—Every item of information should be carefully considered, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65123 (Velivis) D 65123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C. 167

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna DeLevis

(Residence in Baltimore: No. 873 N. Lombard St.; yrs. 23 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. dont Know 1.....
(Month) (Day) (Year)

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, John Wilschusky

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Velivis

(Address) 873 N. Lombard St.

15- JUN 13 1922 Robert P. Harrison, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalations of Illuminating Gas.

(Duration) yrs. mos. 4 hours ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) yrs. mos. ds.

(Signed) H B Gossel M. D.
(Coroner.)

6-13 1922 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	June 14 1922
20-UNDERTAKER,	ADDRESS
John Grebliunas	425 S. Paca St.

(1) Velivis

If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65124

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 515 Jane ave ST., 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Magee

(a) RESIDENCE NO. 515 Jane ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? —yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Magee

6 DATE OF BIRTH (month, day, and year): Feb 22-1845

7 AGE: Years 77 | Months 3 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ——— 00

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Fellis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna Engleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Edith Tarr 515 Jane ave

15 Filed JUN 13 1922, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk Stan

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to June 12, 1922, that I last saw h alive on June 11, 1922, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(No Paralysis)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) old age

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard A Jones, M. D.

19 (Address) Same

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June 14 1922

20 UNDERTAKER: F. B. Kuppert

ADDRESS: 1936 Fait ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65125

CERTIFICATE OF DEATH.

34 D 65125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin & Howard ST., 4 WARD)

2-FULL NAME Louis Katsidrinos

(a) RESIDENCE NO. 220 S Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White Greek

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 28; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steel worker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Robert P. Harrison, Registrar

..... 19 ..... Initial Record Clerk.

N 13 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/9/22

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to June 9, 1922.

that I last saw h. im alive on June 9, 1922

and that death occurred, on the date stated above, at 12:30 Pm.

The CAUSE OF DEATH* was as follows:

1a Sepsis (4th Dorsal)

1b Septicemia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 2. Spine (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hunter S. Pan, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: JUN 1922

20 UNDERTAKER

Commissioner of Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65126

CERTIFICATE OF DEATH.

31 D 65126

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD 14)

2-FULL NAME Dominic Gloria

(a) RESIDENCE. NO. 1401 Division st. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angiolina Gloria

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Carmen Gloria

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Cautta Fonzi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Records
(Address) U. of M. Hospital

15 Filed JUN 13 1922 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1922, to June 10, 1922, that I last saw him alive on June 10, 1922, and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dadaplicco M. D.

6-10-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL JUN 13 1922

20 UNDERTAKER Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65127

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Green

(a) RESIDENCE. No. 1227 Jefferson st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore 074

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Alexander Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records
(Address) M. T. H.

15 Filed JUN 13 1922 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to June 10, 1922, that I last saw h im alive on June 10, 1922, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous arthritis of left knee (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, Xray

(Signed) Francis L. Dalaglisee, M. D.

6-10-22 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS JUN 13 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

08 N1

D 65128 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Bay View ST. 3 WARD) REGISTERED No. C 178

2-FULL NAME Frank Sullivan

(Residence in Baltimore: No. 812 E. Pratt St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, Unknown ..... (Month) ..... (Day) ..... (Year)

7-AGE about 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stone Cutter
(b) General nature of industry, business, or establishment in which employed (or employer) 875

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), U

12-MAIDEN NAME OF MOTHER U

13-BIRTHPLACE OF MOTHER (State or Country), U

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15-

DEC 1922 Burial Permit Clerk

Registrar.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.

(Corner)

June 10 1922 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

DATE OF BURIAL, ..., 19....

20-UNDERTAKER

ADDRESS JUN 1 1922

Body at city morgue

D 65129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65129

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 633 Rabory ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Myers

(Residence in Baltimore: No. 633 Rabory St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Marr

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
50 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Robert P. Harrison, Registrar.
1922, 191, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

6-11-, 1922 (Address) 917 N Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, , 19

20-UNDERTAKER Smith ADDRESS

JUN 13 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65130 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, Ward) 22 1922

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd Chandler.(C)

(Residence in Baltimore: No. 708 S.Charles St. St.; yrs., mos. ds.)

5

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	Colored.	Widower

6-DATE OF BIRTH. Do not know. (Month) (Day) 1..... (Year)

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Virginia.

PARENTS

10-NAME OF FATHER: Do not know.

11-BIRTHPLACE OF FATHER, (State or Country): Do not know.

12-MAIDEN NAME OF MOTHER: Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country): Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Gibbs.(C)

(Address) 708 S.Charles St.

15- June 13 1922 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage,
Due to a stab wound in the chest.
Homicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto T. Bonhage M. D.
(Coroner.)

June, 6 192 (Address) 10.17 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL. 192...

20-UNDERTAKER, Health ADDRESS JUN. 13 1922

GOODALE.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65131

CERTIFICATE OF DEATH.

31 D 65131

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St. Elizabeth's Home (St.) 9 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Marek

(a) RESIDENCE NO. St. Elizabeth's Home St. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 1 — Months: 6 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore (S)

PARENTS

10 NAME OF FATHER Something

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant St. Elizabeth's Home
(Address) [illegible]

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 11 19 22 to June 14 19 22

that I last saw him alive on June 11 19 22

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

(a) Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Louis A. Gu Bruce M.D.

, 19 (Address) 2500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS .....

per Wm. E. WOODALL

Burial Permit Clerk.

MARK should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65132

CERTIFICATE OF DEATH.

31

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2216 McCulloh St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Snowden Savage

(Residence in Baltimore: No. 2216 McCulloh St.; yrs. 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: April (Month) (Day) 1896 (Year)

7-AGE: 24 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Dtl

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Savage

(Address) 2216 McCulloh St.

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. T. B.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Heaney M. D.
(Coroner.)

June 9, 1922 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL, JUN 14 1922

20-UNDERTAKER: Health Commissioner

ADDRESS

Robert P. Harrison, M.D.

CAUSE.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65133 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65133

31

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ossie Richardson

(a) RESIDENCE. NO. Same ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widower

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) D 11

(c) Name of employer

9 BIRTHPLACE (city or town) Riverside, S. C.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant [illegible]
(Address) Warden, Md. Penitentiary

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May - ? , 19 22, to June - 3 , 19 22, that I last saw him alive on June - 3 , 19 22, and that death occurred, on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. 25 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Presence of T.B. Bacillus in sputum

(Signed) William H. Schwarz, M. D.

6/4, 19 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	June 10 19
20 UNDERTAKER Commissioner Health, Per. Wm. S. WOODALL	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

89

1925E MODERN

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001 D 65134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Gisters of the Poor St. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Scott Phillips

(a) RESIDENCE. NO. Preston & Valley Sts. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Dayhoff

6 DATE OF BIRTH (month, day, and year) March 26-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co, Maryland

PARENTS

10 NAME OF FATHER Scott Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Julia Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address) Sr. Florence, Preston & Valley Sts

15 Filed , 19 Registrar

Reb't P. Harrison, 2

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from to record , 19 , to , 19 ,

that I last saw him alive on June 11 , 1922

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

June 13, 1922 (Signed) F. A. Warner, M. D (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	6/15/22

20 UNDERTAKER James M. Stoner

ADDRESS Westminster

Spec.—1-10-21—M&T—1500 Bks.

D 65135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65135

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HERTHA HARRIS ELDER

(a) RESIDENCE NO. Silar City ST., WARD N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mrs Dora Elder

6 DATE OF BIRTH (month, day, and year) Sept 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER E C Elder

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Virginia Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 June 13 1922, 19 Robert L. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUNE 12 1922

17 I HEREBY CERTIFY, That I attended deceased from JUNE 5, 1922, to JUNE 12, 1922, that I last saw h'm alive on JUNE 12, 1922, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

CARDIO-VASCULAR DISEASE

Chronic myocarditis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Myocardial Insuffic.

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) V D Eberman, M. D.

6-13, 1922 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Siler City N. C.

DATE OF BURIAL 6/13 1922

20 UNDERTAKER R A Hughes

ADDRESS West Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65136

D 65136

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 S. Decker Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Eydelloth

(a) RESIDENCE NO. 622 S. Decker Ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Eydelloth

6 DATE OF BIRTH (month, day, and year) Jan. 26-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Loffler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Katherine Gruber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant (Address) John Eydelloth 622 S. Decker Ave

15 Filed 1 3 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1922, to June 11 1922.

That I last saw h[illegible] alive on June 11 1922,

and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Gerring, M. D.

June 12 1922 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL June 14 1922

20 UNDERTAKER Lilly and Feiler ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65137

D 65137

CERTIFICATE OF DEATH.

REGISTERED NO. 14

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2713 Alameda Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma C Kramer

(a) RESIDENCE. No. 2713 Alameda ST., Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas W. Kramer

6 DATE OF BIRTH (month, day, and year): March 1859

7 AGE: Years 63 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer): odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John F. Binder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helen Reich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs George C. Frank (Address) 2713 Alameda Ave

15 Filed 13 1922 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to June 12, 1922, that I last saw h[illegible] alive on June 12, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH was as follows:

Apoplexy

CONTRIBUTORY (Secondary) o (duration) yrs. mos. ds. Arterio Sclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman, M. D.

. 19 (Address) 2232 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: June 15 19 22

20 UNDERTAKER: Harry A. Witzl Co ADDRESS 1531 W Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65138

CERTIFICATE OF DEATH.

88

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 W. Madison ST., 11 WARD)

2-FULL NAME Amanda E Palm

(a) RESIDENCE NO. 313 W. Madison ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman

6 DATE OF BIRTH (month, day, and year) Nov. 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Langer

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Barbara Weisberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Wm F. Davis
(Address) 1433 E Eager St.

15 Filed JUN 1 1922 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-26, 19 22, to June 12 19 22.

that I last saw h alive on June 11, 19 22

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Myocarditis due to Septicemia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Murphy, M. D.

6-12-22 19 (Address) 600 N Patt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL June 17 1922

20 UNDERTAKER Wm Cook — ADDRESS F. G. Hoc.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65139 (1922) D 65139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 3

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Wyncoop

(a) RESIDENCE NO. 315 S. Carlisle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm. Wyncoop

6 DATE OF BIRTH (month, day, and year) June 28-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Julian Cornell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Josephine Ramey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Date 13 1922, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24th 1922, to June 13th 1922, that I last saw her alive on June 13th 1922, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal stenosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia.

Empyema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 12, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) C. Sidney Burwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 6/15 1922

20 UNDERTAKER Wellcare Corp

ADDRESS 502 E May

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65140

CERTIFICATE OF DEATH.

REGISTERED No. C 179

1-PLACE OF DEATH
CITY OF BALTIMORE (a) 3206 Elliott St (St. N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thereisa Banaszewski

(Residence in Baltimore: No. 3206 Elliott St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 10 (Month) (Day), 1920 (Year)

7-AGE, 1 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Casimer Banaszewski

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Shweres

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Banaszewski

(Address) 3206 Elliot St

15- Robert P. Harrison, ..., 191.....

JUN 13 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd Degree burns

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Fell in tub hot water

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton M. D.
(Coroner.)

June 13 1922 (Address) Curtis Bay, Balto. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross Cemetery — DATE OF BURIAL, June 14 1922

20-UNDERTAKER Wendell Dipple & Son — ADDRESS 37 So. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65141

CERTIFICATE OF DEATH.

113 D 65141

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 W 40 to ST., 13 WARD)

2-FULL NAME Ethel M Tittle

(a) RESIDENCE No. 1005 W 40th. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Morris Tittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Studly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Tittle

(Address) 1005 W 40 St

15 JUN 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to June 13, 1922.

that I last saw her alive on June 13, 1922

and that death occurred, on the date stated above, at 2.9, m.

The CAUSE OF DEATH* was as follows:

Convulsions - MD

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Fred W Ward, M. D.

6/13 1922 (Address) 2020 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	June 16 22
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Enters Colitis.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65142

CERTIFICATE OF DEATH.

18 V D 65142

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of Recreation Pier 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Perry Glasgow

(Residence in Baltimore: No. 743 Druid Hill Ave. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	Colored	Single

6-DATE OF BIRTH. ..... Unknown (Month) ....., 1874 (Day) (Year)

7-AGE. 48 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Chas. Glasgow

11-BIRTHPLACE OF FATHER (State or Country) D.C. Md

12-MAIDEN NAME OF MOTHER Margaret Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Talbot Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. Glasgow

(Address) 414 St. Mary St

15-

Filed JUN 14 1922 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 12th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Thos. B. Norton M. D. (Coroner.)

June 13th, 1922 (Address) Curtis Bay, Balto Co Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Laurel Cem	June 14 1922

20-UNDERTAKER Samuel Wensley ADDRESS 578 Bdle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65143

CERTIFICATE OF DEATH.

34 D 65143

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 11 ST., WARD)

2-FULL NAME Charles Allen

(a) RESIDENCE NO. 308 N. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH In plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible] 1881

7 AGE: Years 41 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook. 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Bay View Hospital Balto City, Md.

15 Filed JUN 14 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jun. 4, 1921, to June 12, 1922

that I last saw h[illegible] alive on June 11, 1922

and that death occurred, on the date stated above, at 6.09 p.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Developmental

(Signed) H. L. Edmunds M. D.

6/12/1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: June 15 1922

20 UNDERTAKER: Frank R. Kemsley

ADDRESS: 538 Biddle St

Spec.—1-10-21—M&T—1500 Bks.

D 65144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 65144

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. ..... ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Smith

(a) RESIDENCE NO. 641 McKeldin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 3rd 1910

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
12	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Will Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Rosa Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 19 ..... to June 12th, 1922,

that I last saw h Ha alive on June 12th, 1922,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Meningitis (tuberculous)

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar Puncture

(Signed) Horace G. Stewart M. D.

6/22, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Camden N. J. — DATE OF BURIAL: June 15 1922

20 UNDERTAKER: John H. Toadvine — ADDRESS: 1412 W. Hill St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65145

D 65145

CERTIFICATE OF DEATH.

101

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Gilmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Manine

(Residence in Baltimore: No. 509 N. Gilmor St. St.; 57 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March (Month) 10 (Day), 1864 (Year)

7-AGE, 58 yrs. 3 mos. 00 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Andrew Other

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Susanna Paul

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Manine

(Address) 509 N. Gilmor St

15- Filed JUN 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1922, to June 10 1922, that I saw h-er alive on June 10 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Toxic Pneumonia

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) D. M. Hayes M. D.

6/13, 1922. (Address) 1046 Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, June 14 1922

20-UNDERTAKER John H. Toadvine — ADDRESS 142 Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65146

D 65146

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1918 N. Rose St. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary. A. Hoff

(a) RESIDENCE NO. 1918 N. Rose St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 56 yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: The late John. E. Hoff

6 DATE OF BIRTH (month, day, and year): Not know

7 AGE: Years 75; Months ----; Days ----; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS

10 NAME OF FATHER: John Kuenne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Catherine Yearman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Miss. Lillian. M. Hoff

(Address) 1918 N. Rose St.

15 Filed JUN 14 1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June-12-1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 22 to June 12, 19 22

that I last saw h alive on June 12, 19 22

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Cerebral Hemorrhage

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary): Edema of Lungs.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest L. Lennon M. D.

June 12 19 22 (Address) 928 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 15 1922

20 UNDERTAKER: Henry Horde Son — ADDRESS: 1301 E Eutaw St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65147
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

188-008
D 65147
Registered No. C.....

City of BALTIMORE: (No. 904 E. Eager St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John T. Barrier

(Residence in Baltimore: No. 904 E. Eager St.; yrs. 9 mos. 3 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or ~~Married~~ Divorced. (Write the word.) S

6-DATE OF BIRTH. March 1 1913
(Month) (Day) (Year)

7-AGE. 9 yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Boy
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John W. Barrier

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Minnie Ducky

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Minnie Herring

(Address) 904 E Eager

15-

Filed JUN 14 1922 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 12 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion Brain
accidental blunt, due to
fall from wagon.

(Duration).....yrs.....mos. 1hr.....ds.

CONTRIBUTORY
(Secondary)
.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Mullen M. D.
(Coroner.)
6-13 1922 (Address) 505 E. Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery

DATE OF BURIAL. June 15 1922

20-UNDERTAKER. Henry Horch Son

ADDRESS 1301 E Eager St

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65148

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1217 Smith St. St., 16 Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Wm. R. Lewis .....

(Residence in Baltimore: No. 1217 Smith St. .....St.; yrs., 1 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	single

6-DATE OF BIRTH. ..... May (Month) 13 (Day) 1922 (Year)

7-AGE. .....yrs. 1 mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John H. Lewis

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Pickens

13-BIRTHPLACE OF MOTHER, (State or Country) Balto. Md.

14-THE ABOVE ENTRIES ARE TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Lewis

(Address) 1217 Smith St.

15- .

Filed JUN 14 1922 ROBERT F. KRAMER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... June (Month) 12 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) .....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition,

(Duration) .....yrs.....mos.....ds.

(Signed) J. J. Kennedy, M. D. (Coroner.)

June 14, 1922 (Address) 2302 Eden Street

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt. Auburn Cemetery	June 14 1922

20-UNDERTAKER.	ADDRESS
Jos. F. Dennis	1313 Gressman

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 65149

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 S Central Ave ST.) 3 WARD)

2-FULL NAME Patrick Joseph McDonald

(a) RESIDENCE NO. 419 S Central Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	son to school

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work son to school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Patrick J. McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Ella Farley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Ella Farley (Address) 419 S Central Ave

15 Filed JUN 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to June 13, 1922, that I last saw h alive on June 13, 1922, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

(Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

June 14, 1922 (Address) 412 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Hartford Road	June 16 1922
20 UNDERTAKER	ADDRESS
Wm. H. Appleton	373 Lan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D 65150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 65150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Friedman

(a) RESIDENCE NO. 263 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Friedman

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Copper 1086

(c) Name of employer Smith

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Max Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JUN 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to June 13, 1922, that I last saw him alive on June 13, 1922, and that death occurred, on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

6/13/1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 6/14 1922

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt St

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 65151

CERTIFICATE OF DEATH

114

D 65151

1-PLACE OF DEATH — Registered No. C .....

CITY OF BALTIMORE (No. 719 Redwood St. Ward)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Palmer

(Residence in Baltimore: No. 719 Redwood St.; 2 yrs. 6 mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Dec 21 —, 1919 (Month) (Day) (Year)

7-AGE: 2 yrs. 6 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE (State or country): Balt Co

PARENTS

10-NAME OF FATHER: Wm Palmer

11-BIRTHPLACE OF FATHER (State or country): md

12-MAIDEN NAME OF MOTHER: Ethel Arhik

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE*

(Informant) Wm Palmer

(Address) 719 Redwood St

15-

Filed JUN 14 1922 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June 12, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 11 1922 to June 12 1922, that I saw h— alive on June 11, 1922 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Convulsions following acute Intestinal Indigestion + Cholera (Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Summer heat (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I S Hawkins M. D.

June 3, 1922 (Address) 1202 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: June 14, 1922

20-UNDERTAKER: David Earle — ADDRESS: 916 Pa Ave

D 65152 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 65152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1323 Argyle Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Lucille Douglass

(Residence in Baltimore: No. 1323 Argyle Ave St.; yrs., 9 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.) single

6-DATE OF BIRTH, ... 1922
(Month) (Day) (Year)

7-AGE, ... yrs. 9 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none (child)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Douglass

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Martha Douglass

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Douglass

(Address) 1323 Argyle Ave

15-

JUN 14 1922 192 ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) no history of contagious communications

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

June 13 1922 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Bel Air Md. DATE OF BURIAL, June 14, 1922

20-UNDERTAKER, Jas. Easton ADDRESS 916 Eastern Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 30 D 65153

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2 ST., 7 WARD)

2-FULL NAME Adolph J. Frey

(a) RESIDENCE NO. 1712-16th St. Washington D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of: Bessye Frey

6 DATE OF BIRTH (month, day, and year): 6-6-1875

7 AGE: Years 47; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steamship Offc

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Julius Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Emma Schendzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1922, to June 13, 1922, that I last saw him alive on June 13, 1922, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Coccioidal granuloma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ? California (?)

Did an operation precede death? Yes. Date of April 20, 22

Was there an autopsy? Yes.

What test confirmed diagnosis? Culture. Tissue diagnosis

(Signed) [illegible] M. D.

6-13, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: San Leandro Cal. DATE OF BURIAL: June 14 1922

20 UNDERTAKER: John Mitchell ADDRESS: 1217 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 65154

D 65154

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Chapel ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Mateyka

(a) RESIDENCE. No. 507 N. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Mateyka

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Mateyka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Barbara Mateyka (Address) 507 N. Chapel St.

15 Filed JUN 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to Jun 12, 1922

that I last saw h[illegible] alive on Jun 12, 1922

and that death occurred, on the date stated above, at 1.30P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. H. Rogers, M. D.

Jun. 13 1922 (Address) 506 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	June 14 1922
20 UNDERTAKER	ADDRESS
Ernest Bracken Son	1916 East Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65155 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65155.

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 962 N Chapel ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Stupka

(a) RESIDENCE. NO. 962 N Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Stupka

6 DATE OF BIRTH (month, day, and year) July 1 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles Wolter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohem

12 MAIDEN NAME OF MOTHER Josefa Benedek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohem

14 Informant John Stupka (Address) 962 N Chapel

15 Filed JUN 14 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1 1922 to June 13 1922

that I last saw her alive on June 13 1922

and that death occurred, on the date stated above, at 10 13 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) M Rutzisser M. D.

(Address) 800 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL June 16 19 22

20 UNDERTAKER Frank Grech & Son ADDRESS 1906 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Forms near R.R. Bridge

Registered No. C.....

City of BALTIMORE: (No. Gay & Preston St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Nora Marshall

(Residence in Baltimore: No. 2016 Kayser St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced.~~ (Write the word.) Widow

6-DATE OF BIRTH. ....., 1..... (Month) (Day) (Year)

7-AGE. 36 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. John Marshall

11-BIRTHPLACE OF FATHER. (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Rhoda S Walker

13-BIRTHPLACE OF MOTHER. (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. Julia Marshall

(Address) 2016 Kayser St

15-

Filed JUN 14 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Lesion

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Probably Nephritis

.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Potter M. D.
(Coroner.)

June 12 1922 (Address) 508 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Drake Branch Station Charlotte Va

DATE OF BURIAL. June 22, 1922

20-UNDERTAKER. Mrs Robert A Elliott

ADDRESS 1723 Ashland Ave

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65157 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65157

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Church St. Curtis Bay. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Margaret Pastorek.

(Residence in Baltimore: No. 1 Church St. Curtis Bay. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female.	White.	Single.

6-DATE OF BIRTH. 7 p.m. June 9th. 1922.
(Month) (Day) (Year)

7-AGE. If LESS than 1 day. 4 hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Pastorek.

11-BIRTHPLACE OF FATHER, (State or Country). Poland.

12-~~XXXXXX~~ NAME OF MOTHER. Eva Tweredek.

13-BIRTHPLACE OF MOTHER, (State or Country). Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Iweredek. (mother)

(Address) 1 Church St. Curtis Bay.

15- Filed JUN 14 1922 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 p.m. June 9th. 1922. 19..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

June 10. 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ... 19...

20-UNDERTAKER. ADDRESS JUN 14 1922

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1 Church St. Curtis Bay. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary Pastorek. ---------- 4

(Residence in Baltimore: No. 1 Church St. Curtis Bay. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female.	White.	Single.

6-DATE OF BIRTH. June 9th, 1922, 1.....
(Month) (Day) (Year)

7-AGE. ---yrs.---mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Pastorek.

11-BIRTHPLACE OF FATHER, (State or Country). Poland.

12-MAIDEN NAME OF MOTHER. Eva Iweredek.

13-BIRTHPLACE OF MOTHER, (State or Country). Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Eva Iweredek. (mother)

(Address) 1 Church St. Curtis Bay.

15- Filed JUN 14 1922, 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13th, 1922., 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held un.....inquiry.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
inquiry.....(Inquest, autopsy or inquiry.) find that said deceased came to..his..death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

June 13th 192.. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
	....., 19....
20-UNDERTAKER.	ADDRESS
	JUN 14 1922

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65159

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65159

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1405 Shields Alley St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. W. Dyer

(Residence in Baltimore: No. 684 W. Mulberry St., 48 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
male	colored	Married

6-DATE OF BIRTH. about 1863
(Month) (Day) (Year)

7-AGE. 58 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver 023
(b) General nature of industry, business, or establishment in which employed (or employer) (Team)

9-BIRTHPLACE, (State or Country) Charles Co, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Dyer

(Address) 684 W. Mulberry St.

15-

Filed ..... 192.....

Robert F. Harrison, Registrar.

Burial Permit Clerk.

N 1 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner's (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

June 14, 1922 (Address) 2702 Eastern Ave.

*State the Disease Causing Death, or, In deaths from Violent Cnuses, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, 6-15 1922

20-UNDERTAKER, George K. Holland ADDRESS 1631 Bond St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65160

CERTIFICATE OF DEATH.

179 D 65160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 N. Luzerne Ave ST., 7 WARD)

2-FULL NAME August A. Runge

(a) RESIDENCE NO. 819 N. Luzerne a ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Catherine Runge

6 DATE OF BIRTH (month, day, and year) Sept 8-45

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Stone cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Runge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lena Rausch

(Address) 819 N. Luzerne a

15 Filed 1922, 19 ROBERT F. [illegible], Registrar

Burial Permit Clerk.

41 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 21, to June 13, 19 22,

that I last saw h alive on June 12, 19 22,

and that death occurred, on the date stated above, at 5 40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B. Fischer, M. D.

June 19 22 (Address) 5302 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Cem, DATE OF BURIAL 6/15 1922

20 UNDERTAKER Philip Herwig ADDRESS 2016 Aiken

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65161

HEALTH DEPARTMENT—CITY OF BALTIMORE

17-007 D 65161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Parrish ST.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Bass

(Residence in Baltimore: No. 907 Parrish St.; 1yr. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Oct 26, 1909 (Month) (Day) (Year)

7-AGE: 12 yrs. 6 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: not known

11-BIRTHPLACE OF FATHER (State or Country): not known

12-MAIDEN NAME OF MOTHER: Mary Robinson

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Priscilla Smith

(Address) 907 Parrish St

15- Robert F. Harrison,

Filed ....., 191.....

1 1922 Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12th 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1922, to June 12 1922, that I saw him alive on June 10th 1922, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Hypertrophus Cirrhosis of Kidney (Duration) ....yrs. 2 mos. ....ds.

(Signed) Harry L. Brown M. D.

June 13, 1922 (Address) 150 W Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 6/14/22 191...

20-UNDERTAKER Sam M Chase-son — ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hosp 16 St., Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Harris

(Residence in Baltimore: No. 510 S. Third St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
White	White	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1888 (Year)

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Greece

PARENTS.

10-NAME OF FATHER. —

11-BIRTHPLACE OF FATHER. (State or Country). —

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER. (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Gust Poupetas

(Address) Reno

15- Filed ..... 192.. Robert P. Harrison, Burial Permit Clerk. Registrar.

N 1 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 12 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Accident struck by automobile

June 9/22 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Rib Complications

Pneumonia (Duration) yrs. mos. ds.

(Signed) D. S. Patterson M. D.

(Coroner.)

6-13 192.2 (Address) 5 E. Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	6-15 1922
20-UNDERTAKER.	ADDRESS
Robert Brooks Son	Eutaw & Franklin sts

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65163

CERTIFICATE OF DEATH.

1922 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 N. Smallwood St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Anna Leakin

(Residence in Baltimore: No. 1600 N. Smallwood St.; yrs. 10 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	Married

6-DATE OF BIRTH. about 1884
(Month) (Day) (Year)

7-AGE. 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Samuel Chazinsky

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. D K

13-BIRTHPLACE OF MOTHER. (State or Country). D K.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Dodore Leakin

(Address)..... 1600 N. Smallwood

15- Robert F. Harrison,

Filed JUN 14 1922 192..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 13 192 2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia
(criminal abortion)
(Duration) yrs. mos. 2 8 ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

(Signed) D. J. Hennessy M. D.
(Coroner.)

June 14 192 2 (Address) 2502 Edmondson Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Nebo	6-14 192 2

20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Baltimore St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65164 D 65164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65164 D 65164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 N. 29th St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rep. Tilson Neily

(a) RESIDENCE. NO. 9 N. 29th ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Hand Neily

6 DATE OF BIRTH (month, day, and year) May 28th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant. 045

(b) General nature of Industry, business, or establishment in which employed (or employer) Movie-Vaudeville

(c) Name of employer - - - -

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Neily

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia

12 MAIDEN NAME OF MOTHER Anna Knowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant (Address) Catherine Neily 9 N. 29th St.

15 Filed JUN 15 1922 16 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 19 22, to June 13, 19 22, that I last saw h.. alive on June 13, 19 22, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Arterial Sclerosis. Yrs.

Cerebral Hemorrhage

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Edema of Lung.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest C. Ellwood M. D.

June 14 1922 (Address) 628 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 14 1922

20 UNDERTAKER H. E. Hughes ADDRESS 1101 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be given. Information should be verified, supplied, etc. See instructions on back of certificates. TION is very important.

65165

HEALTH DEPARTMENT—CITY OF BALTIMORE

65165

D 65165

CERTIFICATE OF DEATH.

199 D 65165

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Colgate Creek Sta ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mayd Ott

(Residence in Baltimore: No. 3909 E. Pratt St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Unknown

6-DATE OF BIRTH, Unknown (Month) , 1 (Day) (Year)

7-AGE About 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Round House Fireman at Pa. R. R. Co
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Supposed to be Austria

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Police Sta

15- Filed JUN 15 1922, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sub-dural Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Supposed to have been Morphine Poisoning ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

June 14 1922 (Address) Curtis Bay, Baltimore Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Brooklyn Cemetery — DATE OF BURIAL, June 16, 1922

20-UNDERTAKER A. J. Markel — ADDRESS 35-39 Falls Rd

Spec.—1-10-21—M&T—1500 Bks.

65166 HEALTH DEPARTMENT—CITY OF BALTIMORE 65166

D 65166

CERTIFICATE OF DEATH.

43 D 65166

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Bucks Lane near Groveland Ave. ST., WARD)

2-FULL NAME Joseph Edward Haines

(a) RESIDENCE NO. Bucks Lane near Groveland ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2nd 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or esteblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Edward Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Stitely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co Md

14 Informant Elizabeth L Haines (Address) Bucks Lane, Groveland ave

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 14, 1922, that I last saw him alive on June 13, 1922, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Roof 1 month

(Epithelioma)

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Visible

(Signed) Milton P. Idell, M. D.

, 19 (Address) Wylie ave & Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hollis Burg Pa	June 16 1922
20 UNDERTAKER	ADDRESS
A. D. Marchel	3539 Falls Rd

mation should be entirely supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

B 65167

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 D 65167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Gordon

(a) RESIDENCE NO. 615 N. Paca St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 5 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leslie Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Secretia Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29 - 1922 to June 13 1922

that I last saw her alive on May 13 1922

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, miliary lungs
meningitis

(duration) yrs. mos 2 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Tb clx. Xray

(Signed) F B Gay M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem DATE OF BURIAL Jun 16 1922

20 UNDERTAKER Samuel T Housley ADDRESS 3[illegible]

Reports should be carefully supplied. Any blank should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65168

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 65168

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Harlem ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma R. Becker

(a) RESIDENCE. No. 825 Harlem ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John W. Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhemina Walz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Grace Dauneny
(Address) 825 Harlem ave

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1916, to June 13, 1922

that I last saw ~~her~~ alive on June 13, 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Henry Gut Bayley M. D.

, 19 (Address) 2805 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 15 1922

20 UNDERTAKER	ADDRESS
John B. Spence	1325 N Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65169

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 31 D 65169

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 N Calhoun ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora White

(a) RESIDENCE. No. 1144 N Calhoun ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md

PARENTS

10 NAME OF FATHER James Wilkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Millie Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Irene Stansbury

(Address) 1144 N Calhoun

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1922, to June 13, 1922, that I last saw h[er] alive on June 10, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCaul, M. D.

6/14 1922 (Address) 7005 Hillen Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Md

DATE OF BURIAL 6-15 1922

20 UNDERTAKER Chas H. Close & Son

ADDRESS 1400 Mpd

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65170

D 65170

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 N. Vincent St.: 15 WARD)

2-FULL NAME Mrs. Mary Boston

(a) RESIDENCE. No. 1108 N. Vincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Negress	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 9th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9 BIRTHPLACE (city or town) South River
(State or country) Md.

PARENTS

10 NAME OF FATHER Eugene Boston
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Mildred Calloway
(Address) 1108 Vincent St.

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1922, to June 13th, 1922, that I last saw h. alive on June 13, 1922, and that death occurred, on the date stated above, at 11:05 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Acute)

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Jas. Edw. Gill M. D.
, 19 (Address) 1224 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery
DATE OF BURIAL: June 15 1922

20 UNDERTAKER: Edward Bryson
ADDRESS 1671 Orleans St

D 65171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65171

CERTIFICATE OF DEATH.

Registered No. C 89

1-PLACE OF DEATH: Steamer B. S. Ford.

City of BALTIMORE: (No. Pier 9 Light St. Wharf. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: William J. Taylor.

(Residence in Baltimore: No. 1740 Park Ave. St.; yrs. 45 mos. ds.)

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Single

6-DATE OF BIRTH. January 6th. 1858. (Month) (Day) (Year)

7-AGE. 64 yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Captain
(b) General nature of industry, business, or establishment in which employed (or employer): Stmr. B. S. Ford.

9-BIRTHPLACE. (State or Country). Chestertown Md.

PARENTS.

10-NAME OF FATHER. James F. Taylor.

11-BIRTHPLACE OF FATHER. (State or Country). Kent Co. Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Hurlock.

13-BIRTHPLACE OF MOTHER. (State or Country). Kent Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss. Rachael Ardrich. (niece)

(Address) 1740 Park Ave.

15- JUN 15 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.
Obstruction of Coronard Arteries.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

June 15 1922 (Address) 1917 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park — DATE OF BURIAL. June 16 1922

20-UNDERTAKER. John O. Mitchell — ADDRESS 1701 W. Fayette

Spec.—1-10-21 M&T 1500 Bks.

D 65172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 65172

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3014 Dillon ST., 1 WARD)

2-FULL NAME Gottfried Newman

(a) RESIDENCE No. 3014 Dillon ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Newman

6 DATE OF BIRTH (month, day, and year) Dec. 2. 1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	73	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Copper + Smelting Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Schnitzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa Newman

(Address) 3014 Dillon St.

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 10 1918, to June 12 1922, that I last saw him alive on June 11 1922, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 3 yrs. 5 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Noninsulin

(Signed) W. Woods M. D.

6/14 1922 (Address) 1013 E. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Cemetery

DATE OF BURIAL June 15 1922

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65173

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Harris Freidman

(a) RESIDENCE. No. 6 North Calvert ST., Park ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Freidman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town), (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Louis 1439 E Balto St

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 19 22

17 I HEREBY CERTIFY, That I attended deceased from 6/11, 19 22, to 6/14, 19 22

that I last saw h alive on 6/13, 19 22

and that death occurred, on the date stated above, at 3.05 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation ?

Embolism ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) auricular Fibrillation

(duration) yrs. 3 mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris Paulson, M. D.

19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 6/15 1922

20 UNDERTAKER Jack Louis

ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65174

CERTIFICATE OF DEATH.

14-001

D 65174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 E. Hoffman ST., 8 WARD)

2-FULL NAME Susie Dashiell

(a) RESIDENCE NO. 1512 E. Hoffman ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E. Dashiell

6 DATE OF BIRTH (month, day, and year): Feb 16-1848

7 AGE: Years 74; Months 3; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Cademore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Louisa Cademore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt.

14 Informant: Charles E. Dashiell

(Address) 1512 E. Hoffman St

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 11 = 1922 to June 13 = 1922.

that I last saw her alive on June 13 = 1922,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cerebral Hemorrhage (duration) 1 yrs. 3 mos. 8 ds.

CONTRIBUTORY (Secondary) Paralysis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Walter H. A. Meyer, M. D.

(Address) 1031 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: June 16 1922

20 UNDERTAKER: Frank A. Fink ADDRESS: 918 W. Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65175

CERTIFICATE OF DEATH.

1/13 D 65175

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 2242 Druid Hill Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna M. Dorsey

(a) RESIDENCE. No. 2242 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Henry P. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Naomi Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Henry P. Dorsey
(Address) 2242 Druid Hill Ave.

15 Filed JUN 15 1922 F. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13 1922

17 I HEREBY CERTIFY, That I attended deceased from 5/23, 1922, to 6/13, 1922, that I last saw h... alive on 6/12, 1922, and that death occurred, on the date stated above, at 8:20 m.

The CAUSE OF DEATH* was as follows:

Malnutrition & Marasmus for life
Acute Indestion & Acute
Gastro-enteritis 3 days

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Barksdale, M. D.

, 19 (Address) 2139 Dix. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fair View Cemetery	June 15 1922
20 UNDERTAKER	ADDRESS
Thos J. F. Locke	1302 Jefferson

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

65176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65176

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1604 N. Milford St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. George S. Lotarda

(Residence in Baltimore: No. Abingdon Road St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. unknown ..... 1..... (Month) (Day) (Year)

7-AGE	If LESS than 1 day,
66 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 8 yrs

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER. Morgan

13-BIRTHPLACE OF MOTHER, (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Chaney (daughter)

(Address) 1604 N. Milford

15-

Filed JUN 15 1922 192 [signature] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Acute Heart Failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Howell M. D.
(Coroner.)

6-12 192 2 (Address) 508 E. Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	June 16" 19 22
20-UNDERTAKER.	ADDRESS
Geo M. Funk & Son	811 N Wolfe

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Only here for att 1 wk on visit Monnieday
Came from Abington Md

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas,*	*Peritonitis.*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65177

D 65177

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 Wilcome alley ST., 22 WARD)

2-FULL NAME Ollie Height

(a) RESIDENCE NO. 106 Wilcome alley ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Lemon Height

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Dr. J. Whitehead

15 Filed JUN 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19 .....,

that I last saw h... alive on ....., 19 .....,

and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

8 m

(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. J. Whitehead, M. D.

6/15, 1922 Address 22 Haywood Pl. Balto

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL June 16 1922

20 UNDERTAKER Robert L Parham — ADDRESS 220 Hamburg St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65178 HEALTH DEPARTMENT--CITY OF BALTIMORE Brians 129 D 65178

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 117 Roland Ave St. 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Henry Brians

(Residence in Baltimore: No. 117 Roland Ave St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Mar (Month) 13 (Day), 1833 (Year)

7 AGE: 89 yrs. 3 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Brians

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (State or country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie M. Brians

(Address) 117 Roland Ave

15 JUN 15 1922 Filed ... 191 J. H. Wilson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 14th (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10th, 1922, to June 13th 1922

that I saw h[er] alive on June 13th, 1922,

and that death occurred, on the date stated above, at 1.20 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
of long duration. Contributory
Pulmonic tuberculosis (Duration) 20 yrs. ... mos. ... ds
Contributory (SECONDARY) Senility (Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. H. Travers M. D.

June 14th, 1922 (Address) 2117 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: June 16, 1922

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 65179

D 65179 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 776 W Saratoga ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Green

(a) RESIDENCE. NO. 776 W Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13. 1922

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
				12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Green

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Minnie Green mother
(Address) 776 W Saratoga St.

15 Filed ..... 19 ..... ROBERT R. KRAMER Registrar

JUN 15 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to June 14, 1922,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. 12 hours ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese M. D.

6-14, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS JUN 15 1922

JOHNS HOPKINS HOSPITAL

19289

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Danielak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65180

CERTIFICATE OF DEATH.

33D 65180

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. (ST.) 2 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Danielak

(a) RESIDENCE. NO. 733 S. Bond St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Danielak

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Alexander Danielak 803 Bank St

15 Filed JUN 15 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to June 14, 1922, that I last saw him alive on June 14, 1922, and that death occurred, on the date stated above, at 6:50 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculous Peritonitis

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of June 11, 1922

Was there an autopsy? Not

What test confirmed diagnosis? Laparotomy.

(Signed) J. V. Szczubrski, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross ~~St Stanislaus~~	June 17 1922

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank Street

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6518F

CERTIFICATE OF DEATH. 23 23 90 ✓ Registered No. D 65181

1-PLACE OF DEATH

City of BALTIMORE: (No. 1141 Leadenhall St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Rink. 53 -- 2 ------.

(Residence in Baltimore: No. 1141 Leadenhall St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. April 1869. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
53 yrs. 2 mos. -- ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer. 04
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jacob Rink.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER, Margaret Miller.

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willian Rink. (brother).

(Address) 1513 E. Federal St.

15- Filed JUN 15 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13, 1922, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto H. F. Reinhardt M. D.
(Coroner.)

June 15. 192 2. 1017 S. Charles St.
(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL,
Cedar Hill Cem	June 15 1922
20-UNDERTAKER.	ADDRESS
Margaret L. Flynn	1111 Light St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65182 131 D 65182

D 65182

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 13 WARD)

2-FULL NAME Daniel Dietz

(a) RESIDENCE NO. 1015 Rectory Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Dietz

6 DATE OF BIRTH (month, day, and year): 1838 Jan.-30

7 AGE: Years 83; Months 4; Days 14; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer): 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co., Maryland

PARENTS

10 NAME OF FATHER: Philip Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Rutsinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records. (Address) Municipal Hospital.

15 JUN 15 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1922 to June 13, 1922

that I last saw him alive on June 13, 1922,

and that death occurred, on the date stated above, at 10:55 P.M.

The CAUSE OF DEATH* was as follows:

Pyelonephritis & Cystitis - Resulting from Stricture of External urinary Meatus - cause of stricture not known.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. —

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Brumbeck M. D.

6/14/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 16 1922

20 UNDERTAKER: George L. Schwab — ADDRESS: 2101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

McNeive

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65183

CERTIFICATE OF DEATH.

D 65183

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2007 E. Biddle ST., (or) WARD) 8

2-FULL NAME Anna J. McNeive

(a) RESIDENCE NO. 2007 E Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Wm M. McNeive

6 DATE OF BIRTH (month, day, and year) April 15-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	22	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael P. Ruchniewski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Josephine Carter

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Wm M. McNeive (Address) 2007 E Biddle

15 JUN 15 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1922. to June 13, 1922.

that I last saw h[illegible] alive on June 12, 1922.

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Pul monary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward S. Good M. D.

6/13, 1922 (Address) 413 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	June 16 1922
20 UNDERTAKER	ADDRESS
Mc Ginnis-Carroll	4203 Pedgemead Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Pflugrad)

D 65184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65184

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Pflugrad

(a) RESIDENCE NO. 208 S. 6th St Balto ST., WARD 26th

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Nov- 1876

7 AGE: Years 45 Months 7 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Stembol Germany

PARENTS

10 NAME OF FATHER Thomas Mitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdelina Kohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 15 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 19 22

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ on June 13, 1922, to , 19 ,

that I last saw her alive on June 13, 1922,

and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene, Toxemia from absorption, Thrombosis veins of Rt. leg.

7 days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 6-13-22

Was there an autopsy? No.

What test confirmed diagnosis? Sugar in urine. Operation.

(Signed) Julian C. Hart, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem — DATE OF BURIAL: June 16 1922

20 UNDERTAKER: Peter Nicolaus — ADDRESS: Eastern Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

St. Agnes. 804 Cathedral St.

D 65185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 65185

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 Edmondson Ave. St., 16 WARD)

2-FULL NAME. Julia M Burns

(a) RESIDENCE No. 1314 Edmondson Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF DATE OF BIRTH (month, day, and year): Sept 12 1882

7 AGE — Years: 40 — Months: 9 — Days: 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: George G. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Julia M Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Oscar M. Burns
(Address): 1314 Edmondson Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

NOV 15 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to June 13, 1922, that I last saw h- alive on June 13, 1922, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 322 E. Camey St.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ....

(Signed) W. T. Sherman M. D.

6/14 1922 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 16 1922

20 UNDERTAKER: Wm Cook — ADDRESS: 4 + Gilmor

Spec.—1-10-21—M&T—1500 Bks.

D 65186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65186

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John O'Neill

(a) RESIDENCE NO. 1911 Park Ave. (St.) City (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Do not know

7 AGE: Years: 70 yrs. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): O'N's

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know / Do not Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not Know

14 Informant: Mrs. O'Neill

(Address): 1911 Park Ave.

15 Filed 19 Robert P. Bates Registrar

Balto. Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-14 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1921, to 6-14, 1922, that I last saw him alive on 6-14, 1922, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

3 minutes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension + Arteriosclerosis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Hartman M. D.

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 6/16, 1922

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

JUN 15 1922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65187

D 65187

CERTIFICATE OF DEATH.

REGISTERED NO. X 179

1-PLACE OF DEATH Church Home & Inf. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Broadways Fairmt St. WARD)

2-FULL NAME Judge Fairnat Moore

(a) RESIDENCE NO. 112 Market St. ST., WARD Lancaster S.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5-1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Judge 086

(b) General nature of industry, business, or establishment in which employed (or employer) Circuit Court

(c) Name of employer

9 BIRTHPLACE (city or town) York S.C.
(State or country)

PARENTS

10 NAME OF FATHER Wm A. Moore

11 BIRTHPLACE OF FATHER (city or town) York S.C.
(State or country)

12 MAIDEN NAME OF MOTHER Maria Kay

13 BIRTHPLACE OF MOTHER (city or town) York S.C.
(State or country)

14 Informant Miss Mamie Moore
(Address) Lancaster S.C.

15 Robert P. Harrison, Registrar

JUN 15 1922 .19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/11/ .1922. to 6/14/ .1922.

that I last saw h[illegible] alive on 6/14/ .1922.

and that death occurred, on the date stated above, at 6:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 4 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) Richard G. Corbett, M. D.

.19 (Address) Church Home and Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster S.C. DATE OF BURIAL 6/15 1922

20 UNDERTAKER H E Hughes ADDRESS 412 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65188

CERTIFICATE OF DEATH.

108 D 65188

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 Andre. ST., 24 WARD)

2-FULL NAME Weronika Jakobowska

(a) RESIDENCE NO. 1325 Andre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 11-1916

7 AGE — Years: 5 — Months: 7 — Days: 4 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None, Ohh

(b) General nature of Industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: John Jakobowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Anna Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): John Jakobowski 1327 Andre. St

15 Filed ..., 19 ... Registrar

Robert P. Harrison,

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to June 14, 1922, that I last saw h[illegible] alive on May 27, 1922, and that death occurred, on the date stated above, at 9:50 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Abscessed teeth

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Leonard C Beech, M. D.

June, 19 22 (Address) 2231 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: June 16 19 22

20 UNDERTAKER: William Fialkowski — ADDRESS: 148 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15 1922

D 65189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65189

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. In church of Gilmor & W. Lafayette Ave. Ward) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME. John N. Eward

(Residence in Baltimore: No. 1711 W. Lanvale St., St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. Dec. 7, 1847
(Month) (Day) (Year)

7-AGE. 74 yrs. 6 mos. 7 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Mfg. Agent
(b) General nature of industry, business, or establishment in which employed (or employer). Chemicals

9-BIRTHPLACE. (State or Country). Penna.

PARENTS.

10-NAME OF FATHER. Samuel Eward

11-BIRTHPLACE OF FATHER. (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. U.K.

13-BIRTHPLACE OF MOTHER. (State or Country). U.K.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss Peggie Hartlove
(Address) 1711 W. Lanvale St.

15- Filed JUN 15 1922, 192.. Registrar.
Robert F. Harrison, Deputy Health Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary sclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(Duration) 3 yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)
June 15 1922 (Address) 202 Eddington Bldg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet Cem. DATE OF BURIAL. June 16, 1922

20-UNDERTAKER. C. J. Tuckner & Sons ADDRESS. North Penna. Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 65190

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Ward ST., 21 WARD)

2-FULL NAME Louisa A. Brown

(a) RESIDENCE NO. 1135 Ward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Brown

6 DATE OF BIRTH (month, day, and year): Oct. 27-1853

7 AGE — Years: 69 — Months: 7 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: ? Detmar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Frank Brown 1135 Ward St.

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 19 22 to June 14, 19 22

that I last saw h[illegible] alive on June 12, 19 22

and that death occurred, on the date stated above, at 5. p.m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Cardiac Neuralgia

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M.D. Freiberger M. D.

6/15 19 22 (Address) 682 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Bem. DATE OF BURIAL: June 7 19 22

20 UNDERTAKER: Wm. J. Tickner & Sons ADDRESS: N. Y. Pa

INSTRUCTIONS. Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65191

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Edward Sweet

(Residence in Baltimore: No. Union Bridge Md St.; yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. ..... about Know ..... 1..... (Month) (Day) (Year)

7-AGE. 18 yrs. 6 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Brakeman '13
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Union Bridge Md

PARENTS.

10-NAME OF FATHER. Harry M. Sweet

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Rosie Crabbs

13-BIRTHPLACE OF MOTHER. (State or Country) Union Bridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Crabbs

(Address) Union Bridge Md

1922

Filed ..... 192 ..... Clerk. .....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... June ..... 5 ..... 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Meningitis

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Fractured skull due to an accident

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W R Gorsuch M. D. (Coroner.)

6-15 1922 (Address) 117 W Lanvale St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Carroll Co. Md Mount Union

DATE OF BURIAL. 6/16 1922

20-UNDERTAKER. H Bankard & Son

ADDRESS Westminster Md

This University Hospital Baltimore Md

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R. R. Accident

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 65192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

GOD 65192

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 E-21 ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A Nicoll

(a) RESIDENCE NO. 308 E-21 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora C. Nicoll

6 DATE OF BIRTH (month, day, and year) Aug 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg. agt.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) "

PARENTS

10 NAME OF FATHER William Nicoll

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Dora C. Nicoll

(Address) 308 E. 21 St. 58

15 Filed , 19 Registrar

15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 11, 19 22 to June 14, 19 22,

that I last saw h[illegible] alive on June 13, 19 22,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema of Heart

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. J. Talbot, M. D.

6/15, 19 22 (Address) 6 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 6/15 1922

20 UNDERTAKER John A Moran — ADDRESS 3000 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65193

CERTIFICATE OF DEATH.

139 D 65193

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bertha Mannel

(a) RESIDENCE NO. 822 Woodley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert F Mannel

6 DATE OF BIRTH (month, day, and year) March 18 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	2	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Frederick Rossa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Albert F. Mannel

(Address) 822 Woodley St.

15 JUN 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to June 13, 1922, that I last saw her alive on June 13, 1922, and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Post Operative shock

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hysterectomy for Complicated by Pelvic Abscess uterine injuria ?

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of June 13, 1922.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E A Neusser, M. D.

6/14, 1922 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL June 16 1922

20 UNDERTAKER Mrs. Mrs John H. Tenfel & Son

ADDRESS 201 E Fayette St

Instructions: Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, aud consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The patient did not have a cancer.

E E Duncan.

Spec.—1-10-21—M&T—1500 Bks.

D 65194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001
161 D 65194

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1 N. Highland Ave ST., 76 WARD)

2-FULL NAME George Howard Mowbray

(a) RESIDENCE NO. 1 N. Highland ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Otley R. Mowbray

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Dodson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Otley R. Mowbray
(Address) 1 N. Highland Ave

15 JUN 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15. 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 1922, to June 15, 1922,
that I last saw him alive on June 15, 1922,
and that death occurred, on the date stated above, at 11.30 a. m.
The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Premature Birth 8 mo

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

6/15. 1922 (Address) 330 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	June 16 1922.
20 UNDERTAKER	ADDRESS
Tilly and Zieler	403 S. Wolfe St.

IMPORTANT SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65195

CERTIFICATE OF DEATH.

128 D 65195

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 225 (St.) Jasper (Ward) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Williams

(a) RESIDENCE. No. 225 St., Jasper Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE — Years: 58 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: Dr Dawson

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Dr Kenon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dixie Kenon

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: [illegible]
(Address)

15 Filed JUN 16 1922 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/5 —, 1922, to 6/13 —, 1922, that I last saw h[illegible] alive on 6/13 —, 1922, and that death occurred, on the date stated above, at 7 47 m.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis & Uremia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Burkett, M. D.

, 19 (Address) 1139 W. Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Jun 15 1922

20 UNDERTAKER: David Easton — ADDRESS 716 Penn

Spec.—1-10-2I—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65196

CERTIFICATE OF DEATH.

146 D 65196

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3036 Philadelphia ave ST. 6 WARD)

2-FULL NAME Anna V. Fowler

(a) RESIDENCE NO. 3036 Philadelphia ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard A Fowler

6 DATE OF BIRTH (month, day, and year) Oct 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Balt

PARENTS

10 NAME OF FATHER Antone Parisen

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ellen

12 MAIDEN NAME OF MOTHER Rose Ostal

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Balt

14 Informant Howard A Fowler

(Address) 3036 Philadelphia ave

15 JUN 16 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 19 22

17 I HEREBY CERTIFY, That I attended deceased from January 7, 19 22, to June 19, 19 22, that I last saw h alive on June 14, 19 22, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 5 weeks mos ds.

CONTRIBUTORY (Secondary) Puerperal Septicemia following Nephritis (duration) yrs. 3 weeks mos ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M. D.

June 16 1922 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL ... 19

20 UNDERTAKER Wendell Doyle & Son — ADDRESS 3738 Eastern

Assist. Transit Clerk

Matron should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65197

159-002

CERTIFICATE OF DEATH.

REGISTERED NO. D 65197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Fulton ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna R. Stahlfine

(a) RESIDENCE. NO. 1527 Fulton ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 20, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Martin G Stahlfine

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Hare

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant. Martin G Stahlfine
(Address) 1527 Fulton St

15 JUN 16 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to June 15, 1922, that I last saw her alive on June 15, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Patent Foramen ovale

(duration) ..... yrs. 2 mos. 25 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) E. or John Kerr M. D.

6/16, 1922 (Address) 1 E Pendleton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Emmanuel Cem	6-16 1922

20 UNDERTAKER Mrs Chas A G. Rhode — ADDRESS Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65198 | CERTIFICATE OF DEATH. | 31 D 65198

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 232 N Arlington ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. H. Kellum

(a) RESIDENCE. No. 232 N Arlington St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	LESS than 1 day, hrs. or min.
	46 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mary E. Kellum

(Address) 232 N. Arlington Ave

15 Filed JUN 16 1922, 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from May, 19 22, to June 14, 19 22, that I last saw h... alive on June 13, 19 22, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Abscess

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? T.B. Bac

(Signed) J. Worrell M. D.

, 19 (Address) 1817 Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 18 1922
20 UNDERTAKER David Easton	ADDRESS 916 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65199

CERTIFICATE OF DEATH.

161-002

D 65199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N. Monroe ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Butler.

(a) RESIDENCE NO. 1315 Monroe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/13/22

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Eugene Butler.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Queen.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant (Address)

15 JUN 16 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/22 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/13, 1922, to 6/15, 1922, that I last saw him alive on 6/14, 1922, and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) rapid labor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Bruns, M. D.

6-15, 1922 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUN 17 1922

20 UNDERTAKER

ADDRESS

Commissioner of Health.

Burial Permit

Station should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 65200

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hosp.

CITY OF BALTIMORE: (No.) ST., 25 WARD)

2-FULL NAME (Baby) Boyd

(a) RESIDENCE NO. 11 Union Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14 1922

7 AGE Years Months Days If LESS than 1 day, ~~hrs.~~ or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boots City (State or country)

PARENTS

10 NAME OF FATHER HARRY E Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Colorado

12 MAIDEN NAME OF MOTHER Nellie McCannon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Nellie Boyd (mother) (Address) 11 Union Ave

15 Filed JUN 16 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/14/22, 1922, to 6/19/22, 19 .

that I last saw him alive on 6/14/22, 19 ,

and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Harper, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL June 16 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65201

CERTIFICATE OF DEATH.

D 65201

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST., 25 WARD)

2-FULL NAME Abraham Coffindaffer

(a) RESIDENCE NO. Beulah W. Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. C. Coffindaffer

6 DATE OF BIRTH (month, day, and year) Aug 9-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66 yrs.	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): W. Va

PARENTS

10 NAME OF FATHER: Christian Coffindaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant: Clarke Yates (Address) Salem W. Va

15 Filed JUN 16 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/22

17 I HEREBY CERTIFY, That I attended deceased from 6/2/22, 19..., to 6/15/22, 19...

that I last saw him alive at 7.15 p.m. 6/16/22 19...

and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

? (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Cancum

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 6/7/22

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. W. Scott M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem W. Va	June 19 22

20 UNDERTAKER: F B Hupfeld 2236 Fred Ave

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65202

CERTIFICATE OF DEATH.

90D 65202

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1857 Kavanaugh (St.) 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ford.

(a) RESIDENCE. No. 1857 Kavanaugh St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Alice Ford.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Prince George County Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Unknown

14 Informant Annie Young (Address) 1118 Woodland Ave

15 2[illegible] JUN 16 1922 ROBERT R. KRAUTER, Registrar

4[illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to June 13, 1922, that I last saw him alive on June 13, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease,

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Clinical.

(Signed) John D. Queen, M. D.

6/13, 1922 (Address) 1507 N. Dutton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 16 1922
20 UNDERTAKER	ADDRESS
Jno W Greer & Son	1400 Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name of disease alone should be stated. LAY OR PHYSICIANS should state. AGE should be carefully supplied.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65203

CERTIFICATE OF DEATH.

100 001 D 65203

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2126 E. Fayette ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M. Gnau

(a) RESIDENCE. NO. 2126 E. Fayette ST., 6 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 3 mos. 30 ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.
(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name, Color, Age, Sex, Single, Married, Widowed, or Divorced, Occupation, Birthplace, Residence, Cause of Death, Duration of Disease, Physician's Address, Date of Death, Burial Permit, Undertaker, Cemetery Supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Barbara Gnau

6 DATE OF BIRTH (month, day, and year) Feb. 15/1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry G. Gnau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant: Mrs. Barbara Gnau
(Address) 2126 E. Fayette St

15 FILED JUN 16 1922 — ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922, to June 14, 1922

that I last saw him alive on June 13, 1922.

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bronchus = Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Auscultation & Percussion

(Signed) Adolph C. Eisenberg, M. D.

June 15, 1922 (Address) 1101-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	June 19 1922
20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 N. Eutaw ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65204

31

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Jonkins Alley ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada Underwood

(Residence in Baltimore: No. 1021 Jonkins St.; ....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1905 (Year)

7-AGE, 17 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER, Phillip Underwood

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Edith Smith

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Underwood

(Address) 1021 Jonkins

15-

Filed JUN 16 1922 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1922, to date 1922, that I saw her alive on ..... 191..., and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

a Pulmonary Tuberculosis

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) J D Lutes M. D.

June 15, 1922 (Address) 211 N Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, June 17 1922

20-UNDERTAKER James A Deems

ADDRESS 1303 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 pds.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 65205

001

D 65205

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 N. Gilmore St. WARD 16)

2-FULL NAME Catharine Tracy Osbourn

(a) RESIDENCE NO. 1624 N Gilmore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. Clay Osbourn

6 DATE OF BIRTH (month, day, and year) May 2 1845

7 AGE: Years 77 | Months 1 | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Basil Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Mrs. Grace Robb. (Address) 1624 N. Gilmor St

15 Filed JUN 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8 1922 to June 15 1922, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

H

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Valvular Heart Disease

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stuart Robb M. D.

(Address) 1624 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL 6/17/1922

20 UNDERTAKER: Wm Cook, 501 E. North ave. — ADDRESS

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65206

D 65206

CERTIFICATE OF DEATH.

78.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 E Biddle ST., 8 WARD)

2-FULL NAME William J. Roth

(a) RESIDENCE NO. 2043 E Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer) — 014

(c) Name of employer Same: Wm A. Roth

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Wm A. Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Wm A. Roth, (Address) 2043 E. Biddle St

15 JAN 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to June 15, 1922, that I last saw him alive on June 14, 1922, and that death occurred, on the date stated above, at 3 15 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

(duration) yrs. mos ds.

Epilepsy

CONTRIBUTORY (Secondary) (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) T. E. Hanes M. D.

June 16, 1922 (Address) 1301 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6/19/1922

20 UNDERTAKER Wm Cook, 507 E. North ave.

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65207 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 65207

CERTIFICATE OF DEATH. 74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3820 Resterstown Rd (ST.) 27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Taggart

(a) RESIDENCE. No. 3820 Resterstown Rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Elizabeth A. Taggart

6 DATE OF BIRTH (month, day, and year) Sep. 11. 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Undertaker 086

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Pittsburg Penna.

PARENTS

10 NAME OF FATHER John Taggart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Ackley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburg Penna

14 Informant Geo. R. Carr (Address) 3820 Resterstown Rd

15 JUN 16 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12 1922 to June 15 1922

that I last saw him alive on June 15 1922

and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Bubert M. D

. 19 (Address) 4857 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa.

DATE OF BURIAL 6/16/22 19

20 UNDERTAKER Wm. Cook.

ADDRESS 502 E Fallsth

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65208

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Simmons

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis, (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed 6 16 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922. to June 16, 1922.

that I last saw her alive on June 15, 1922.

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Clyde McNeill, M. D.

6/16/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bur Auburn Cmty — DATE OF BURIAL 6-18 1922

20 UNDERTAKER George T. A. Gibson — ADDRESS 513 Lanvale St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 65209

1 PLACE OF DEATH

CERTIFICATE OF DEATH

1798 D 65209

REGISTERED NO. C

CITY OF BALTIMORE (No. 1803 E. Preston St.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary agnes Wehrman

(Residence in Baltimore: No. 1803 E Preston St. St.: 51 yrs. 7 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Nov. 9, 1870 (Month) (Day) (Year)

7 AGE: 51 yrs. 7 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Martin Daily

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Mooney

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gussie Daily

(Address) Bealfus & Frazier ave

15

Filed ....., 191 .....

Robert P. Harrison, REGISTRAR

JN 16 1922 Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 15, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2. 1922. to. June 15 1922.

that I saw h alive on June 14. 1922.

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. 13 ds

Contributory (SECONDARY) Decompensation of Heart

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Thos F Stevens M. D.

6/16, 1922 (Address) 2878 Harford rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: June 19, 1922

20 UNDERTAKER: Margaret J. Flynn

ADDRESS: 1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65210

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St.: 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Cain

(a) RESIDENCE. No. Georgetown Road St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept. 23-~~1865~~ 1864

7 AGE: Years 57 Months 8 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Labor.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Balto. City

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Cain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Garvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Peter Ward.
(Address): Georgetown P.O. Md.

15 Filed June 6 1922 Robert P. Harrison, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6 1922 to June 14 1922
that I last saw him alive on June 14 1922
and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency
Coronary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Cancer of Prostate

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? yes Date of June 1922
Was there an autopsy? Not
What test confirmed diagnosis? Topography
(Signed) J. V. Szymecki, M. D.
(Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peter's Cem. DATE OF BURIAL: June 7 1922

20 UNDERTAKER: Margaret J. Flynn ADDRESS: 1422 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

W 1

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65211

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2839 Rayner Ave. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Hammond

(a) RESIDENCE. No. 2839 Rayner Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes P. Hammond

6 DATE OF BIRTH (month, day, and year) Aug. 29 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Syracuse N. Y.

PARENTS

10 NAME OF FATHER George M. Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary Kellog

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant (Address) Mrs. Agnes P. Hammond 2839 Rayner Ave.

15 June 16 1922, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

N 16 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 15, 1922.

that I last saw him alive on June 15, 1922

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Malignant Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place Death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Phys. Examination

(Signed) John A. Gurland, M. D.

June 16 1922 (Address) 121 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M.E. Church Reisterstown	6/17 1922
20 UNDERTAKER	ADDRESS
I. Frew McCully	1306 Fort

Before signing, be certain all items are correctly answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE, 001 D 65212

D 65212

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 E. Eager (St.;) 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur B. Cole

(a) RESIDENCE. No. 710 E. Eager St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James A. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Katherine E. Shaughnessy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) James A. Cole 710 E. Eager St.

15 Filed 1922 Robert P. Garrison, Registrar

Dr. Brack Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922 to June 15, 1922 that I last saw h alive on June 15, 1922 and that death occurred, on the date stated above, at 8. a m.

The CAUSE OF DEATH* was as follows:

Purpura Hemorhagica

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Jefferies Busk M. D.

19 (Address) 2844 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer DATE OF BURIAL: June 17 1922

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmt Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65213

CERTIFICATE OF DEATH.

90 D 65213

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N. Paca ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles de Green

(a) RESIDENCE. No. 512 N. Paca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 35 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Protzman

6 DATE OF BIRTH (month, day, and year) April ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	66	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St. Mary's Seminary

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER -------- de Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Caroline de Green
(Address) 512 N. Paca Street

15 Filed ..., 19.. [illegible] Harrison, Registrar

JUN 16 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 15, 1922, that I last saw h[illegible] alive on June 12, 1922, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of the Heart

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) about 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chronic Interstitial Nephritis & Dropsy

(Signed) Charles O'Donovan, M. D.

, 19 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	6/17, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65214 — HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65214 + 159-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. , ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Wolfe

(a) RESIDENCE NO. Marion Center ST., WARD Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 16 1913

7 AGE: Years 9 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Edward Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Eva Burkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Robert P. Harrison,

15 Filed 19 Registrar: 6 16 1922 Burial Permit Clerk;

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16th, 1922, to June 15th, 1922, that I last saw him alive on June 15th, 1922, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus.

(duration) 9 yrs. 2 mos ds.

CONTRIBUTORY (Secondary): none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at birth

Did an operation precede death? Yes Date of May 20, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) P B Mac Cready, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fleming Summit Pa — DATE OF BURIAL: June 16 1922

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bang

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65215

CERTIFICATE OF DEATH.

135 D 65215

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 512 Cathedral ST.: 11 WARD)

2-FULL NAME Elias Glenn Prime

(a) RESIDENCE. No. 512 Cathedral St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 93 yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Eliza Ridgely Brall Washington

6 DATE OF BIRTH (month, day, and year) June 14th 1829

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
93			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Private affairs

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER David Mauldin Prime

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Town Maryland.

12 MAIDEN NAME OF MOTHER Mary Glenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elkton Cecil Co. Md.

14 Informant Washington Prime (Address) 607 Cathedral St.

15 Filed JUN 16 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to June 14, 1922, that I last saw h.im alive on June 14, 1922, and that death occurred, on the date stated above, at 9 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute prostatis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Prostatitis

ACD (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Walter E Platt M. D.

, 19 (Address) 502 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 17th 1922

20 UNDERTAKER Henry W. Jenkins & Sons Co. ADDRESS Orchard & McCulloh St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65216

D 65216

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Ritzer

(a) RESIDENCE. No. 1206 W. Lexington ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Ritzer

6 DATE OF BIRTH (month, day, and year) 5/7/1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wm Ritzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Anna Shoemaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Josephine Ritzer 1206 W Lexington

15 Filed JUN 16 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/10/ 1922, to 6/15 1922, that I last saw him alive on 6/15 1922, and that death occurred, on the date stated above, at 12:55 P.M.

The CAUSE OF DEATH* was as follows:

Gangrene of Foot - Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation Hypostatic pneumonia.

(duration) yrs. mos. ds.

18 Where was disease con(racted if not at place of death? 1206 W Lexington

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Longhurst, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manassas Va. DATE OF BURIAL 6/17 1922

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

IMPORTANT.—THIS IS A LEGAL RECORD. Every item in the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not diabetic.
Senile gangrene.

Spec.—8-24-14—M. & T.—2000 Bks.

(Triumpo)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65217 D 65217

CERTIFICATE OF DEATH.

REGISTERED No. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 East ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josefine Triumpo

(Residence in Baltimore: No. 418 East St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, May 31, 1906 (Month) (Day) (Year)

7-AGE, 16 yrs. 2 mos. 15 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). none

9-BIRTHPLACE, (State or Country), Baltimore city

PARENTS.

10-NAME OF FATHER Mariano Triumpo

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Angela Bonanno

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mariano Triumpo

(Address) 418 East St

15- Filed JUN 16 1922, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan June 15 1922 to June 15 1922, that I saw h[illegible] alive on June 15 1922, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Uremia (Convulsions

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. 3 mos. ....ds.

(Signed) Wm. L. Donaldson M. D.

June 16, 1922 (Address) 1038 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents — DATE OF BURIAL, 6/17, 1922

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Hanford Av

JUN 16 1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. Information as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65218

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65218

CERTIFICATE OF DEATH

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Inf

CITY OF BALTIMORE: (No. 2 Broadway ST. E. WARD 19)

2-FULL NAME Mrs. Amanda Bird

(a) RESIDENCE NO. 1704 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel R Bird

6 DATE OF BIRTH (month, day, and year) Oct 19 - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Staum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Elizabeth Rosa

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs. Hardesty (Address) 1704 W. Lombard

15 JUN 16 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1922, to June 15, 1922, that I last saw h[illegible] alive on June 15, 1922, and that death occurred, on the date stated above, at 4:15 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) Cayetano Lavellera, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL June 17 1922

20 UNDERTAKER W. J. Tickner & Sons

ADDRESS N Y Ave

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 65474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65219 X 135 D 65219

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 7

2-FULL NAME William Conner

(a) RESIDENCE NO. 1005 Windsor Ave. WARD Bristol, Tenn

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. (mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Molly Conner

6 DATE OF BIRTH (month, day, and year) Mch 17-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	71	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet metal worker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER Jas. M. Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Grim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Robert F. Harrison, , 19 Registrar

Burial Permit Clerk.

JUN 1 0 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 25th 1922 to June 9th 1922

that I last saw him alive on June 9th 1922

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic hypertrophy

Uremia

(duration) 5 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Pyonephrosis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Tenn.

Did an operation precede death? yes Date of 5-17-22

Was there an autopsy? yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Cecil H. Bagley, M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bristol Tenn. DATE OF BURIAL 6/10/22 19

20 UNDERTAKER H C Hughes & Son ADDRESS Bristol Tenn

NEW—WRITE PLAINLY, WITH PENCIL OR PEN. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65220

CERTIFICATE OF DEATH.

57 D 65220

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3240 Cedar Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Hare

(Residence in Baltimore: No. 3240 Cedar Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Feb. 1, (Month) (Day) 1868 (Year)

7-AGE,	If LESS than 1 day,
54 yrs. 4 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired 321

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Lewis Rice

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Keller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Rupp

(Address) 25 N Highland Ave

15-

Filed....., 191.....

Robert F. Harrison,
Registrar.
Burial Permit Clerk.

JUN 16 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1922, to June 16 1922, that I saw h[er] alive on June 16 1922, and that death occurred, on the date stated above, at 5 20 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Dames M. D.

June 16 1922. (Address) 8 E. Mt. Vernon Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Carlton and DATE OF BURIAL, June 19, 1922

Grave Run Hospital

20-UNDERTAKER J S Mac Hall ADDRESS 3539 Fall Rd

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6522I

74-001

D 6522I

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 720. W. 34 St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Litchfield

(Residence in Baltimore No. 720 W. 34 St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 9 (Month) (Day), 1846 (Year)

7-AGE, 76 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labor.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, John H Litchfield

11-BIRTHPLACE OF FATHER (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER Mary Seaver

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Swartzbaugh

(Address) 720 W. 34th St

15-

Filed ....., 191.....

Robert F. Harrison, Registrar.

Burial Permit Clerk.

JUN 16 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to h death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Coroner D.

June 15 1922 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, June 17, 1922

20-UNDERTAKER C. D. Marshall

ADDRESS 3539 Falls Road

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65222

D 65222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO. 11

CITY OF BALTIMORE: (No. 16 ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Geiselman

(a) RESIDENCE. NO. 1532 W. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. A. Geiselman

6 DATE OF BIRTH (month, day, and year) 1/27/1867

7 AGE: Years 55 | Months 4 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Co Md

PARENTS

10 NAME OF FATHER: Josiah G. Stately

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Eiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Charles A Geiselman, 1532 W Saratoga St

Filed JUN 17 1922, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/1922

17 I HEREBY CERTIFY, That I attended deceased from 5/13, 1922, to 6/15, 1922, that I last saw her alive on 6/15, 1922, and that death occurred, on the date stated above, at 8.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Obstruction
Perforation - Peritonitis - (Obstruction - Cardiac decompensation)

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus Pneumonia decompensation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1532 W Saratoga St

Did an operation precede death? yes Date of 5/13/22 & 6/13/22

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W D Douglas, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Jun 17 1922

20 UNDERTAKER: H. M. Routson — ADDRESS: 2235 Ma

WHILE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65223 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 18 D 65223

REGISTERED No. C .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Foot of Linn St. St.; 16 Ward)

2-FULL NAME Mary Queen

(Residence in Baltimore: No. 925 Vincent Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Single

6-DATE OF BIRTH, ..., 1902
(Month) (Day) (Year)

7-AGE, 20 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country) Balto Co Md.

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country) Don't know

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Denl Eaton

(Address)..... 916 Penn

15- Filed ....., 191.....

Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., June 15th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned off Starlight boat

(Duration) ..... yrs. ..... mos. ..... ds.

Supposed to have Knocked CONTRIBUTORY overboard

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Horton M. D.
(Coroner.)

June 15th, 1922 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	June 17, 1922
20-UNDERTAKER Denl Easton	ADDRESS 916 Penn

WRITE PLAINLY, with unfailing ink. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Filed June 17 1922 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65224

CERTIFICATE OF DEATH.

31

D 65224

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 684 Pierce ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Martin

(a) RESIDENCE. No. 684 Pierce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Martin

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Mathias Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sallie Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant David Easton

(Address) 916 Pierce

15 Filed JUN 17 1922, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1922, to June 16, 1922, that I last saw her alive on June 16, 1922, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Phthisis

(duration) yrs. one mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John R. Lacey, M. D.

19 (Address) 703 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 17 19
20 UNDERTAKER David Easton	ADDRESS 916 Pierce

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65225

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 Parish Alley ST., 16th (or WARD)

2-FULL NAME Georgia Pannell

(a) RESIDENCE NO. 1217 Parish Alley ST. 16th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 6 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Clark Pannell (Deceased)

6 DATE OF BIRTH (month, day, and year) 1878-12 mo-25 day.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Amms. Va.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: David Eaton
(Address) 916 Druid

15 Filed 6/19/1922 Robert P. Harrison, Registrar

Burial Permit Clerk

JUN 17 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/1922

17 I HEREBY CERTIFY, That I attended deceased from 2/18, 1922, to 6/15/, 1922, that I last saw h[illegible] alive on 6/13/, 1922, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pyorrhea Alveolaris (duration) yrs. [illegible] mos. [illegible] ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Jackson, M. D.

6/19/1922 (Address) 765 N. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: June 17 1922

20 UNDERTAKER: David Eaton — ADDRESS: 916 Druid Pa

Spec.—1-10-21—M&T—1500 Bks.

D 65226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65226

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2028 W. Pratt ST. 20 WARD)

2-FULL NAME Mrs Hedwig Ruhe

(a) RESIDENCE NO. 2028 W Pratt ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): marr

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Friedrich Ruhe

6 DATE OF BIRTH (month, day, and year): July 7-1863

7 AGE — Years: 58 — Months: 11 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Moritz F. Bernhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frederick Ruhe

(Address): 2028 W. Pratt St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JN 17 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1922, to June 15, 1922

that I last saw her alive on June 14, 1922

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

, 1922 (Address) 1- S. Pt Brooke Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 18 1922

20 UNDERTAKER: George E. Schwab — ADDRESS: 1101 Eutaw Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis.
No cerebral hemorrhage.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65227

CERTIFICATE OF DEATH.

D 65227

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 W. Lanvale St. 17 Ward)

REGISTERED NO. 1611

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Doney

(a) RESIDENCE. No. 612 W. Lanvale St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER Robert Doney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mabel Armstrong

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Robert Doney
(Address) 612 W Lanvale St

15 Filed June 19 [illegible] Harrison, Registrar

JN 17 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 13th, 1922, to June 16th, 1922, that I last saw him alive on June 15th, 1922, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Thoms Reese M. D.

6-16, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	6/17/22
20 UNDERTAKER	ADDRESS
Jolly & Son	102 E Mulberry St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65228

CERTIFICATE OF DEATH.

185 D 65228

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 N. Eutaw St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Buckman

(a) RESIDENCE. No. 734 N. Eutaw ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. Buckman

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
94				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant George Buckman
(Address) 734 N. Eutaw St

15 Filed , 19
Robert P. Harrison, Registrar

JUN 17 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 29, 19, to June 14/22, 19, that I last saw her alive on June 14/22, 19, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Fracture of Right Femur

result of a fall (duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George L. Dunn M. D.

6/15/22, 19 (Address) 721 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone Chapel	June 17 19 22
20 UNDERTAKER Daniel Easton	ADDRESS 617 E. Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65229

CERTIFICATE OF DEATH.

31 D 65229

1-PLACE OF DEATH US. Veterans' Hospital #56
Fort. McHenry Md.
CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry O. Wagenen

(a) RESIDENCE NO. 801 Park ave Baltimore ST., Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) ..... --
(c) Name of employer ..... --

9 BIRTHPLACE (city or town) (State or country) ..... Virginia.

PARENTS
10 NAME OF FATHER ---
11 BIRTHPLACE OF FATHER (city or town) (State or country) --
12 MAIDEN NAME OF MOTHER --
13 BIRTHPLACE OF MOTHER (city or town) (State or country) --

14 Informant Hospital records
(Address) Fort. McHenry Md.

15 JUN 17 1922 19 Robert P. Harrison, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to June 15, 1922, that I last saw him alive on June 15, 1922, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:
Tuberculosis pulmonary active.
Nephritis paremchymatous.

-- (duration) - yrs. - mos. - ds.

CONTRIBUTORY (Secondary) --
--- (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of --
Was there an autopsy? No
What test confirmed diagnosis? Lab. Clinic report.

(Signed) H D Luke Surgeon (R) M. D.
6/15 1922 (Address) US.V. Hosp. #56 Ft. McHenry Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL June 17, 1922

20 UNDERTAKER S. Levinson & Bro ADDRESS 1127 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Veterans' Hospital #56

CITY OF BALTIMORE: (No. Fort. McHenry Md. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robinson.

(a) RESIDENCE NO. Shiloh, King George Co. ST., Virginia. WARD

(Usual place of abode) (If noo-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
33		--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital records.

(Address) Fort. McHenry Md.

15 Filed JUN 17 1922, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1922 to June 14, 1922.

that I last saw him alive on June 14, 1922.

and that death occurred, on the date stated above, at 5'10 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis. far. adv. & active.

-- (duration) - yrs. - mos - ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage.

(duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Lab. Clinic report.

(Signed) [signature] Surgeon (R) M. D.

6/14 1922 (Address) US.V. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 6/17 1922

UNDERTAKER S. Levinson & Bro

ADDRESS 1127 E. Balto St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65231 D 65231

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth's Home St., 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Brooks

(Residence in Baltimore: No. St. Eliz. Home St.: yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S.

6-DATE OF BIRTH, August 15, 1921 (Month) (Day) (Year)

7-AGE, yrs. 10 mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Gertrude Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hanna Brooks

(Address) 111 E. Mulberry St.

15-

Filed ... 191.. [illegible] Registrar.

JUN 17 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1922, to June 16 1922, that I saw h... alive on June 15 1922, and that death occurred, on the date stated above, at 11.25 a.m.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Lewis A. M. Krauss M. D.

June 16, 1922 (Address) 1500 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 6-17, 1922

20-UNDERTAKER George A. Holland ADDRESS 103 W. Mulberry St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65232

CERTIFICATE OF DEATH.

D 65232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) (Ward) 2 118

REGISTERED NO. 8-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Taylor

(a) RESIDENCE. No. 229 S. Broadway St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Taylor

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sign painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Amer. Ice Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Albers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M.T.H.

15 Filed 7 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1922, to June 15, 1922, that I last saw him alive on June 15, 1922, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia (broncho)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Spasmotic Intestinal Obstruction (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Francis L. Palaglisea M. D.

6-15-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: 6/17/1922

20 UNDERTAKER: Wm Levort, 502 E. North ave — ADDRESS

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ON 1

Spec.—1-10-21—M&T—1500 Bks.

D 65233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 65233

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N. West. ST., 21 WARD)

2-FULL NAME Agnes K. Smith

(a) RESIDENCE NO. 511 N. West. ST., ... WARD 21

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): ..... (Single)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar 28-1903

7 AGE — Years: 19 — Months: 2 — Days: 19 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk Coll

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: Albert E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chicago Ill.

12 MAIDEN NAME OF MOTHER: Lillie Wessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs. Albert E. Smith

(Address): 511 west West St.

15 Filed ..... 19 .....

1922 Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June-16-1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 ..... 19 22 to June 16 ..... 19 22,

that I last saw h.er alive on June 11 ..... 19 22,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Tuberculous Kidney removed Jan 1921 (duration) Unknown mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Irving Cook Wellis, M. D.

, 19 (Address) 811 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: June 19 1922

20 UNDERTAKER: Wm Cook — ADDRESS: E. Nathan

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65234

CERTIFICATE OF DEATH.

D 65234

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 Westwood ave. ST.; 45 WARD)

2-FULL NAME Benjamin Lee Ford

(a) RESIDENCE. NO. 2406 Westwood Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ford

6 DATE OF BIRTH (month, day, and year): March 31. 1877

7 AGE — Years: 45 — Months: 2 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): Maryland Casualty Company

(c) Name of employer: Baltimore County

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas W. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Harriet A. Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Thomas W. Ford
(Address)

15 Filed Robert P. Harrison, Registrar

JUN 17 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to June 15, 1922, that I last saw h[illegible] alive on June 15, 1922 and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 20, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	June 19 1922
20 UNDERTAKER	ADDRESS
Wm Cook	503 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65235

148

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 12 WARD)

2-FULL NAME Edna Jones

(a) RESIDENCE NO. 1527 Bond St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced (or) WIFE of Clarence Jones

6 DATE OF BIRTH (month, day, and year) March 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	19	3½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home Duties

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joe Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Millie Parham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. Records. (Address)

15 Filed ....., 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to June 14, 1922, that I last saw h[illegible] alive on June 14, 1922, and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Eclampsia (Toxaemia of Pregnancy)
Myocardial insufficiency
Pulmonary oedema

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) ..... (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H H Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery — DATE OF BURIAL June 17 1922

20 UNDERTAKER Mrs Robert - A Elliott — ADDRESS 1725 Ashland Av

JUN 17 1922

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65236

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

2-FULL NAME Ida Robinson

(a) RESIDENCE NO. 241 Etting or 211 Edding St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co., (State or country) Maryland

PARENTS

10 NAME OF FATHER Isiah Keller

11 BIRTHPLACE OF FATHER (city or town) Balto., (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Harris

13 BIRTHPLACE OF MOTHER (city or town) Balto., (State or country) Maryland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed JUN 17 1922 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1922, to June 15, 1922, that I last saw h er alive on June 15, 1922, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Baumbach, M. D.

6/16/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 6 18 June 1922

20 UNDERTAKER Edward Brosnahan &

ADDRESS 1631

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65237

CERTIFICATE OF DEATH.

90

D 65237

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. N WARD)

2-FULL NAME Chas. H. McElwel

(a) RESIDENCE. NO. Bay View Asylum. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed 6/17/22 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1922

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1920, to June 15, 1922, that I last saw him alive on June 15, 1922, and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

6/16/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL June 17 1922

20 UNDERTAKER Robt S Turner Inc

ADDRESS 1442 W Broadway

D 65238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65238

CERTIFICATE OF DEATH.

Registered No. C 7165

1-PLACE OF DEATH

City of BALTIMORE: (No. 2336 Eager St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Firstbrick

(Residence in Baltimore: No. 2336 Eager Pl. St.; 15 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Married

6-DATE OF BIRTH: June (Month) 22 (Day) 1907 (Year)

7-AGE: 14 yrs. 11 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mch. Operator
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing Mfg

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: John Kober

11-BIRTHPLACE OF FATHER, (State or Country): Bohemia

12-MAIDEN NAME OF MOTHER: Barbara Panek

13-BIRTHPLACE OF MOTHER, (State or Country): Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Kober (mother)

(Address) 2336 Eager Pl.

15- Robert P. Harrison, 192 Registrar.
Burial Permit Clerk.

JUN 17 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day) 192x (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry, find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride - Mercury Poisoning
Taken with Suicidal intent
on June 10/22 11 30 PM.

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. F. Potter M. D.
(Coroner.)

June 16th 192x (Address) 108 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Bohemian National Cemetery June 18 192

20-UNDERTAKER. ADDRESS
Henry Hoeck Son 1301 E Eager St

No. 1—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65239

CERTIFICATE OF DEATH.

D 65239

1074-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor; 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret O'Hagan.

(a) RESIDENCE. NO. Preston Valley 4th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John O'Hagan

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Timothy Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence Dept. (Address) Little Sisters of the Poor

15 Filed JUN 17 1922, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from No record, 19.., to ..., 19..., that I last saw her alive on June 11, 1922, and that death occurred, on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

June 17, 1922 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	June 17 1922

20 UNDERTAKER J. E. Weidefeld

ADDRESS 814 Gramont Av

JN 17 1922

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of QUESTION is very important. See instructions on back of certificates.

D 65240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 2418 D 65240

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Off of Hull Street. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.) En route

2-FULL NAME Daniel A. Howard.

(Residence in Baltimore: No. 328-28th. St. Newport News. St.; yrs. ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. ..... 1..... (Month) (Day) (Year)

7-AGE. 48 yrs. ---------- mos. ---------- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of Industry, business, or establishment in which employed (or employer). Restaurateur.

9-BIRTHPLACE, (State or Country). Pennsylvania.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Dr. Louis Loeb.

(Address) 2912 West St. Newport News

15-

Filed ..... 192.....

Registrar.

JUN 17 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15th. 1922. ..... 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from power boat
Virginia. (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) Otto M. Reinhart M. D.
(Coroner)

June 16 2. 1017 S. Charles St.
192.... (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Philadelphia Pa	6 17 1922

20-UNDERTAKER. George J. Ruth

ADDRESS 1735 Harford Av

Robert P. Garrison, Burial Permit Clerk.

USE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks. (Laura Camphor) v

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6524I 101-01 D 6524I

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Shields Place ST.; 17 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Camphor

(Residence in Baltimore: No. 901 Shields place St.; 59 yrs. — mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, June (Month) ....., 1863 (Year)

7-AGE, 59 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Palestine Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret A. Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Cole

(Address) 901 Shields Place

15- Filed ....., 191..... Registrar.

JUN 17 1922

Robert T. Harrison

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 9 1922, to Jun 16 1922, that I saw h.. alive on Jun 16 1922, and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows: Pulmonary TB

.....

.....

..... (Duration) 7 yrs. 9 mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) ..... M. D.

Jun 16, 1922 (Address) 714 S. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, June 18 1922

20-UNDERTAKER Jno H. Toadvine — ADDRESS 143 W. Hill St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65242

CERTIFICATE OF DEATH.

84

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3519 Orleans ST.; 6 WARD)

2-FULL NAME Adam Seibert

(a) RESIDENCE. No. 3519 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Kath Seibert

6 DATE OF BIRTH (month, day, and year) Jan. 3 1863

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Seibert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany —

12 MAIDEN NAME OF MOTHER Eliz. England.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany —

14 Informant Catherine Seibert (Address) 2519 Orleans St.

15 Filed ..., 19 ... Registrar

JN 17 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1921, to June 15, 1922, that I last saw h[illegible] alive on June 15, 1922, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Huntington's Chorea

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Concussion of Brain.

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis A. Mc. Krause M. D.

, 19 (Address) 3500 E. Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	6/18 1922
20 UNDERTAKER Philip J Hennig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

O.K.

J. St. Colen M.D.
Coroners Northeastern

Known from horse drawn Wagon
struck by Auto
Aug. 1921 - Had recovered from
effect of accident.

Spec.—1-10-21—M&T—1500 Bks.

12330 65243 D 65243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65243 × 32 D 65243

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Rose D. Bible

(a) RESIDENCE NO. Lexington Ky ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Frank O. Bible

6 DATE OF BIRTH (month, day, and year) Aug 14-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER C. Frank Henriot

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Marie Bonbolet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4. 1922 to June 16. 1922.

that I last saw her alive on June 16. 1922.

and that death occurred, on the date stated above, at 3.45 P.m.

The CAUSE OF DEATH* was as follows:

Tumor of the cerebellum

Tuberculoma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) operation (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 9

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chippewa Falls, Wisconsin — DATE OF BURIAL June 17 1922

20 UNDERTAKER John O. Mitchell — ADDRESS 130 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65244 HEALTH DEPARTMENT—CITY OF BALTIMORE 65244

D 65244

CERTIFICATE OF DEATH. 31

D 65244

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1708 Johnson ST. 24 WARD)

2-FULL NAME William L. Frantz

(a) RESIDENCE. NO. 1708 Johnson ST. 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 9-14-1884

7 AGE: Years 37 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Benj. Frantz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Mary Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Frantz (Address) 1708 Johnson St.

15 Filed JUN 18 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to June 16, 1922, that I last saw h alive on June 16, 1922, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. T. Bayne, M. D.

6/16, 1922 (Address) 6 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 6/19 1922

20 UNDERTAKER: John J. Fahey & Son

ADDRESS: 318 Eighth St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65245 D 65245

CERTIFICATE OF DEATH.

X 49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella I. Roberts

(a) RESIDENCE NO. Westminster Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 11-7-1855

7 AGE: Years 68 Months 2 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Wakefield Maryland

PARENTS

10 NAME OF FATHER: Wm England

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Maryland

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 18 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 18, 1922, that I last saw her alive on June 18th, 1922, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF PANCREAS

DIABETES MELLITUS

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) DIABETIC ACIDOSIS

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster — DATE OF BURIAL: 6/22 1922

20 UNDERTAKER: H H Bankard & Son — ADDRESS: Westminster Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65246

CERTIFICATE OF DEATH.

10 ✓

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. (Or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Fineman

(a) RESIDENCE. NO. 2515 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 22 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Morris Fineman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Sandberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant M. Fineman (Address) 2515 McCulloh St

15 FILED JUN 18 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to June 17, 1922, that I last saw him alive on June 17, 1922, and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 19 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cultures (+)

(Signed) B. MacLaurin M. D.

6/18/22 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	June 18 1922

20 UNDERTAKER M. Levinson ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65247

CERTIFICATE OF DEATH.

90

REGISTERED NO. D 65247

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 610 S. Regester ST., V WARD)

2-FULL NAME Julia Stepanczak.

(a) RESIDENCE NO. 610 S. Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): ~~June 29~~ Dec 11 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	2	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of Industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Theodore Stepanczak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Eva Jakusiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Theodore Stepanczak

(Address): 610 S Regester

15 Filed JUN 18 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1922, to June 17, 1922,

that I last saw her alive on June 17, 1922,

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs + symptoms

(Signed) Luther C. Kraeuthel M. D.

6/19 1922 (Address) 2323 Eastern Ave.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Evangelical

DATE OF BURIAL: 6/19 1922

20 UNDERTAKER: William Fialkowski

ADDRESS: 1418 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65248

CERTIFICATE OF DEATH.

159 1923

D 65248

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1406 W Mulberry ST., 19 WARD)

2-FULL NAME Margaret Elizabeth Green

(a) RESIDENCE No. 1406 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — nil

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. city.
(State or country)

PARENTS

10 NAME OF FATHER David E Green

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Etta R. Penly

13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country)

14 Informant David E Green
(Address) 1406 W Mulberry

15 FILED JUN 1 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to June 17, 1922

that I last saw h[illegible] alive on June 17, 1922

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions

(Chronic Kidney - Nephritis

Acute - Kidney Stones)

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. Lapp M. D.

June 17 1922 (Address) 2303 N Calvert.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery, DATE OF BURIAL: June 19 19

20 UNDERTAKER: Geo J Smith ADDRESS: Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65249

D 65249

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1951 W. Fayette ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Jeffers

(a) RESIDENCE. No. 1951 W Fayette ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~ ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Boswell Jeffers

6 DATE OF BIRTH (month, day, and year) Feb. 9th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Michael Buckingham

11 BIRTHPLACE OF FATHER (city or town) ~~Howard~~ (State or country) Co. Md

12 MAIDEN NAME OF MOTHER Nellie Buckingham

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md

14 Informant James M Jeffers

(Address) 25 S. Calhoun St

15 Filed JUN 18 1922, 19

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 17, 1922, that I last saw her alive on June 16, 1922, and that death occurred, on the date stated above, at 12 25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. O'Neill, M. D.

6/18, 1922 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 6-19th 1922

20 UNDERTAKER: Robert Brooks & Son

ADDRESS S. E. Cor Calhoun Hollins Sts

Curtis 0006

D 65250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D 65250

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2310 Cambridge ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George F. Bahnmline Sr

(Residence in Baltimore: No. 1558 Carswell St

St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, October 15th, 1862
(Month) (Day) (Year)

7-AGE, 59 yrs. 8 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labrer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Geo. F. Bahnmline

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary E. Hamill

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. F. Bahnmline Jr

(Address) 1558 Carswell St

Filed JUN 18 1922, 191... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Indigestion

10 minutes (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Geo. B. Horton M. D.
(Coroner.)

June 16th 1922 (Address) Curtis Bay, Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. | DATE OF BURIAL, 6/19/22, 19...

20-UNDERTAKER Chas. P. Ward & Son | ADDRESS Ward Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65251

CERTIFICATE OF DEATH.

44 D 65251

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1208 N. Calvert St. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma T. Peirce Slocum

(a) RESIDENCE No. 1208 N.Calvert St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Slocum

6 DATE OF BIRTH (month, day, and year) Sept.10.1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Peirce

11 BIRTHPLACE OF FATHER (city or town) R.I. (State or country)

12 MAIDEN NAME OF MOTHER Mary A.C. Phillips

13 BIRTHPLACE OF MOTHER (city or town) R.I. (State or country)

14 Informant George W. Slocum

(Address) 1208 N.Calvert St.

15 JUN 18 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18. 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19th, 1921 to June 18th, 1922 that I last saw h er alive on June 17th, 1922, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver---metastasis after removal of breast

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? Yes Date of July 12'21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

June 18 1922 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount = | DATE OF BURIAL June 20 1922

20 UNDERTAKER John O. Mitchell & R. Tryett | ADDRESS

B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Cordelia A. Mitchell

D 65252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65252

CERTIFICATE OF DEATH.

X 90

REGISTERED No. C

1-PLACE OF DEATH Homewood Hosp.

CITY OF BALTIMORE: (No. 2724 N. Charles ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cordelia A. Mitchell

(Residence in Baltimore: No. 2724 Charles St.; 40 yrs., mos. 21 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, DIVORCED.~~ (Write the word.) Widow

6-DATE OF BIRTH, Dec. (Month) 7 (Day), 1881 (Year)

7-AGE, 40 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Churchville Md

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Frances Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Mitchell

(Address) 2752 McCulloh

15- Filed JUN 19 1922, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June (Month) 18 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 29 1922 to June 18 1922 that I saw h[illegible] alive on June 18 1922 and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

June 18, 1922 (Address) 2724 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Perryman Md.

19-PLACE OF BURIAL, OR REMOVAL. Perryman Md. DATE OF BURIAL. 6/15, 1922

20-UNDERTAKER Wm. J. Tiehner & Son ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Bks.

65253 HEALTH DEPARTMENT—CITY OF BALTIMORE 65253

D 65253 CERTIFICATE OF DEATH. X 199 D 65253

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lafayette W. Graham

(a) RESIDENCE NO. Hinton, W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. L. W. Graham

6 DATE OF BIRTH (month, day, and year) May 15-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40	40	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER L. A. Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Octavia Sumner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) ROBERT A. KRAUTER,

15 Filed JUN 19 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17th, 1922, to June 18th 1922.

that I last saw h live on June 18th, 1922,

and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

1 Fracture of skull

2 Bronchopneumonia 2 days.

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) 1 Meningitis, pyogenic

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Ullman, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hinton W Va — DATE OF BURIAL June 18 1922

20 UNDERTAKER Wm. G. Schaffer — ADDRESS 1816 Monument

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jugella Cady.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65254

CERTIFICATE OF DEATH.

90 D 65254

1-PLACE OF DEATH Municipal Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ... St.: N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jugella Cady

(a) RESIDENCE. No. Bay View St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson Cady

6 DATE OF BIRTH (month, day, and year) ? 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Hosp Records

15 Filed JUN 19 1922 ROBERT R. KRAUSER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17-1922

17 I HEREBY CERTIFY, That I attended deceased from 6-1-20 to 6-17-1922 that I last saw h alive on 6-17-1922 and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D

1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Laurel Cemetery June 19 1922

20 UNDERTAKER — ADDRESS

Chas. N. Johnson 416 N. Carolin

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 65255

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4213 Wickford Road ST.: Roland Park WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hasie Ebeling White

(a) RESIDENCE. No. 4213 Wickford Rd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 Single, ~~Married~~, Widowed, or Divorced (write the word) Widowed Widow

5a ~~M~~ married, widowed, ~~divorced~~ (or) WIFE of Henry K. White

6 DATE OF BIRTH (month, day, and year) July 3? 1866

7 AGE 56? Years 56 Months ~~Days~~ 11 mos 17 Days ~~wks~~ If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Rev Geo W. Ebeling

11 BIRTHPLACE OF FATHER (city or town) Salzgitter (State or country) Germany

12 MAIDEN NAME OF MOTHER Hasie Reidel

13 BIRTHPLACE OF MOTHER (city or town) Salzgitter (State or country) Germany

14 Informant Wm Ebeling
(Address) 1228 Hotchkiss Bldg

15 Filed JUN 19 1922 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 23 19 22 to June 16 19 22 that I last saw h 9/ alive on June 16 19 22 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast removed, two years ago

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Lung (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological

(Signed) Robt C. Gebhart, M. D.

6/17 19 22 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salem Lutheran Cem Catonsville

DATE OF BURIAL: June 19 19 22

20 UNDERTAKER: Henry W. Kirkwood & Sons Co

ADDRESS: Mitchell & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65256

D 65256

25-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.) ST., 10 WARD)

2-FULL NAME Mary Harrison

(a) RESIDENCE NO. 1413 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. 5 mos. 2 5 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Harry Harrison

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Jenne

13 BIRTHPLACE OF MOTHER (city or town) Rumania (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUN 19 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17th, 1922, to June 18th, 1922, that I last saw her alive on June 18th, 1922, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chicken Pox

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J B Gay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL June 19 1922

20 UNDERTAKER Ed Levin & Bro ADDRESS 1127 E. Balto St

I. B. WRITE PLAINLY, with indelible pencil.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 65257

CERTIFICATE OF DEATH.

117 D 65257

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert F. Manzke

(a) RESIDENCE NO. 1008 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret E. Manzke

6 DATE OF BIRTH (month, day, and year) Apr. 13 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	31	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Counterman as

(b) General nature of industry, business, or establishment in which employed (or employer) Lunchroom 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Martin A. Manzke

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna E. Henderot

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Margaret E. Manzke

(Address) 1008 W. Fayette St

15 Filed JUN 19 1922 ROBERT R. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18 - 1922

17

I HEREBY CERTIFY, That I attended deceased from 6-15- , 1922, to 6-18- , 1922,

that I last saw ~~him~~ alive on 6-18- , 1922

and that death occurred, on the date stated above, at 12 45- A m.

The CAUSE OF DEATH* was as follows:

Acute Sup. Appendicitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/15/22

Was there an autopsy? no

What test confirmed diagnosis? Op. findings

(Signed) Newton S. Carr, M. D.

6/18/1922 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western cemetery — DATE OF BURIAL June 20 1922

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65258

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1420 Holbrook St. ST., 9 WARD)

2-FULL NAME F. William. Kerchner

(a) RESIDENCE NO. 1420 Holbrook St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. -- mos. 12 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June-6-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	------	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 089

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Ferdinand Kerchner

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna. B. Linnenkamper

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Miss. Anna. C. Kerchner
(Address) 1420 Holbrook St

15 Filed JUN 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-18-1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1922, to June 18, 1922, that I last saw him alive on June 17, 1922, and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis + insufficiency of all the Valves

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

June 19 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: June-21-22

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

D 65259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65259

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospl. WARD) 14

2-FULL NAME Mrs Flora Dantoni (Salvatora)

(a) RESIDENCE NO. 2307 Penna Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Salvatore Dantoni

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 53 yrs. — Months: — — Days: — — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Ignazio Charles Falicci

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Francesca Paolo Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Jos Dantoni

(Address) 2307 Pennsylvania

15 Filed JUN 19 1922 ROBERT R. KRAUTER, (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15 1922 to June 16 1922

that I last saw h alive on June 16 1922

and that death occurred, on the date stated above, at 8.00 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma.

Myocardial Insuf.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma liver.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. W. Scott M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: June 19 1922

20 UNDERTAKER: Martin Fahey & Sons

ADDRESS 831 W North Ave

A. B. WRITE CLEARLY, with pen and ink. USE NO ABBREVIATIONS. ANSWER EVERY question. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65259

Baltimore, Md.,
February 15, 1926.

This is to certify that there personally appeared before me, a Notary Public in and for the City of Baltimore, Joseph Dantoni, who made oath to the following statements.

That the following corrections should be made on Baltimore City Department of Health Certificate of Death D-65259, date of death June 16, 1922.

The name of the deceased should be recorded as MRS. SALVATORA DANTONI instead of MRS. DORA DANTONI; the name of the father should be recorded as IGNAZIO FALISI instead of CHARLES FALICE; and the maiden name of the mother should be recorded as FRANCESCA PULEO instead of "Unknown", as stated on said certificate.

Subscribed and sworn to before me this 15th day of February, 1926.

Joseph Dantoni
Son.

Notary Public.

Spec.—1-10-21—M&T—1500 Blks.

D 65260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65260

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2438 Ashland Ave. WARD)

2-FULL NAME Lenard Stanley

(a) RESIDENCE NO. 2438 Ashland Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Edgar L Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Becky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Edgar L Stanley (Address) 2438 Ashland Ave

15 Filed JUN 19 1922 ROBERT N. KRAUTER Registrar Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 28 1922, to June 17 1922, that I last saw h— alive on June 16 1922 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

CONTRIBUTORY (Secondary) Premature Birth (duration) yrs. mos. 20 ds.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Adam B Lemmon M. D.

6/18 1922 (Address) 718 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 19 1922

20 UNDERTAKER Woodall & Upchurch — ADDRESS 3[illegible] Penn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 65261

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 151 W. Lafayette Ave. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia B. D. Short

(a) RESIDENCE. No. 151 W. Lafayette Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4th, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	--	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Warwick
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Hall Short

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Martha E. Humphrey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Delaware

14 Informant Miss Emma Short
(Address) 151 W. Lafayette Ave

15 Filed JUN 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1922, to June 17, 1922, that I last saw h er alive on June 17, 1922, and that death occurred, on the date stated above, at 8. A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 6. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davies, M. D.

6-17 1922 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Smyrna Rental Delaware	June 22 1922
20 UNDERTAKER	ADDRESS
V Beckham & Gore	1723 W Lafayette Ave

D 65262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65262

CERTIFICATE OF DEATH.

168

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 147 N. Highland Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest A. McKinney

(Residence in Baltimore: No. 147 N. Highland Ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Nov. 18th, 1909 (Month) (Day) (Year)

7-AGE, 12 yrs. 6 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School boy
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Edward H. McKinney

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lettie Green

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Eckes

(Address) 29 N. Eleventh St.

15- Filed JUN 19 1922 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs.....mos.....ds.

(Signed) Thos. B. Horton M. D. (Coroner.)

June 17 1922 (Address) Curtis Bay, Balto. Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, June 19 1922

20-UNDERTAKER H. M. Routon

ADDRESS 225 N. Pine St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST. 28 WARD)

REGISTERED NO. 122 D 65263

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo L. Stump

(a) RESIDENCE. NO. 5002 Ferndale ave ST., ... WARD. .....
(Usual place of abode) Howard Park (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 13 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52 yrs	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Po. R.R. Balto.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo L. Stump

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Stroh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) University Records.

15 Filed JUN 1 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922, to June 17, 1922, that I last saw him alive on June 17, 1922, and that death occurred, on the date stated above, at 4.45A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia
Lower

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertrophy Prostate, Gastro Intestinal Catarrh

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? History and Clinical Findings

(Signed) L. H. Culver, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Woodlawn Cem June 19 1922

20 UNDERTAKER — ADDRESS
Wm Tickner & Son North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65264

CERTIFICATE OF DEATH.

129 D 65264

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Rose Hill Terrace Ward 9)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Rinker

(a) RESIDENCE NO. 500 Rose Hill Terrace St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Rinker

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer): 025

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John Rinker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Whitmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: R B Miller

(Address): 500 Rose Hill Terrace

15 JUN 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922 to June 16, 1922

that I last saw him alive on June 15, 1922

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Dilatation of Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) C Hartenbach, M. D.

, 19 (Address) 817 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 19 1922

20 UNDERTAKER: W J Uckner Bro

ADDRESS: North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65265

D 65265

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin G. Keller

(Residence in Baltimore: No. 3103 Walbrook ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	S

6-DATE OF BIRTH, March 4 (Month) (Day) 1921 (Year)

7-AGE, 1 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Balt City

PARENTS.

10-NAME OF FATHER, Edward P. Keller

11-BIRTHPLACE OF FATHER, (State or Country). Frederick Co

12-MAIDEN NAME OF MOTHER, Lillian Downey

13-BIRTHPLACE OF MOTHER, (State or Country). Balt Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Burkett

(Address) Annearundel Co

15-

JUN 19 1922 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17 (Month) (Day) 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull from fall. Fracture of both bones of left forearm on contents walking accident

(Duration) yrs. mos. 6 hr ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H Fenton M. D. (Coroner)

June 17 192.. (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 3103 walbrook ave

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	June 19 192..
20-UNDERTAKER, John F Denny	ADDRESS 715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

65266

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 65266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Shelter for Aged Colored Persons (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza West

(a) RESIDENCE. No. Shelter (517 W Biddle St) ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Matron Shelter

(Address) 517 W. Biddle St

15 Filed JUN 19 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18/1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 18, 1922.

that I last saw her alive on June 16, 1922

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diffuse arteriosclerosis Cerebral hemorrhage

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Simpson, M. D.

(Address) 1019 Dulaney Valley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sharp St M E Cem June	19 1922
20 UNDERTAKER	ADDRESS
Chas E. Fraser	502 Madison Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65267

CERTIFICATE OF DEATH.

K 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospt ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Callie A. Smith

(a) RESIDENCE No. 12 of Colonial Ave Norfolk Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 15 How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65 yrs.		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Haven Conn

PARENTS

10 NAME OF FATHER: John Wilcox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Killingsworth Conn

12 MAIDEN NAME OF MOTHER: Harriet Coe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Middletown Conn

14 Informant: Edwin A Smith

(Address): Norfolk Va

15 Filed JUN 1 9 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19th 1922

17

I HEREBY CERTIFY, That I attended deceased from June 10th, 1922, to June 19th, 1922.

that I last saw her alive on June 18th, 1922

and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Sigmoid

Not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of June 10th 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. G. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Conn — DATE OF BURIAL: June 21 1922

20 UNDERTAKER: Robert Brockerson — ADDRESS: Calhoun Parlors

D 65268

HEALTH DEPARTMENT—CITY OF BALTIMORE

1003

1822 D 65268

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1124 E 20th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Sullivan

(Residence in Baltimore: No. 1124 E 20th St.; yrs. 45 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH, July (Month) 6 (Day) 1876 (Year)

7-AGE, 50 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Roofer
(b) General nature of industry, business, or establishment in which employed (or employer) 886

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Hubley Sullivan

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary E. Farrell

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sullivan (wife)

(Address) 1124 E 20th

15- Filed JUN 19 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Cerebral Hemorrhage
Struck by Automobile May 12/22
on Fallsway near Centre

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Fuller M. D.
(Coroner.) North Eastern
6-16 1922 (Address) 1 E Pleasant

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. June 20 1922

20-UNDERTAKER, E. A. Wiedefeld ADDRESS 501 E 22 St

8

R. S. 5—Every item of information should be carefully supplied. All blanks should be filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65269

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2843 Freemont Ave ST.: 9 WARD)

2-FULL NAME David Edward Coggins

(a) RESIDENCE. (No.) 2843 Freemont Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Lawrence Coggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Della Yerger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lawrence Coggins
(Address) 2843 Freemont Ave

15 JUN 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 16th, 1922, to June 17th, 1922

that I last saw him alive on June 17th, 1922

and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Errors

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Young Jr M.D., M. D.

6/17/22 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	June 19 1922
20 UNDERTAKER E. A. Windsfeldt Sr	ADDRESS 501 E 22 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65270 | 113 | D 65270

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N. Streeper ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Geo. Tuckel.

(a) RESIDENCE NO. 202 N. Streeper ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 6th 1921

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. 0d

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George T. Tuckel

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Marie Wakefield

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant George T. Tuckel
(Address) 202 N. Streeper St.

15 Filed JUN 19 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922, to June 16, 1922, that I last saw him alive on June 16, 1922, and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Intussusception

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Benj. D. Hamlin M. D.

6/18, 1922 (Address) 20 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 19 1922

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

65271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 65271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 275 N. Exeter St ST., 5 WARD)

2-FULL NAME Leba Gordon

(a) RESIDENCE NO. 275 N. Exeter ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gordon

6 DATE OF BIRTH (month, day, and year) Sep. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher (Hebrew) 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Vitebsk Russia

PARENTS

10 NAME OF FATHER Taehum Solonoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Rosett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sophie Rosett
(Address) 41 Guy Street

15 Filed JUN 19 1922 ROBERT R. KNAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1922 to June 18, 1922.

that I last saw her alive on June 18th, 1922

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-Ray, Gastric anal &c.

(Signed) B Pushkin, M. D.

Jun 11 1922 (Address) 1804 Eutaw pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workmen Circle Clem

DATE OF BURIAL 6/19 1922

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

Polokoff

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65272

D 65272

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 Eagle ST., 70 WARD)

2-FULL NAME Rachael Polokoff

(a) RESIDENCE NO. 2043 Eagle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Barney Polakoff

6 DATE OF BIRTH (month, day, and year): Nov 15/1867

7 AGE: Years 54 Months 8 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 600

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Baltimore

15 Filed JUN 19 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1921, to June 19, 1922, that I last saw her alive on June 19, 1922, and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. 1 hour ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 7 mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan B Bordenky M. D.

6/19 1922. (Address) 2114 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrenbach Rd

DATE OF BURIAL: 6/19 1922

20 UNDERTAKER: Jack Lewis 1439 E Balto

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65273

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 228 N Collington Ave. (St.) 6 (WARD)

2-FULL NAME Fanny B. Dillies

(a) RESIDENCE NO. 228 N Collington Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm G. Dillies.

6 DATE OF BIRTH (month, day, and year): Nov 7 1853

7 AGE: Years 68 | Months 7 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Christian Hackett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm G Dillies

(Address): 228 N Collington Ave

15 JUN 19 1922 ROBERT R. KNAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1921, to June 17th, 1922.

that I last saw h[illegible] alive on June 17th, 1922

and that death occurred, on the date stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows:

~~Chronic Interstitial Nephritis~~

Uraemic Coma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Longenbach, M. D.

June 19 1922 (Address) 2129 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: June 20 22

20 UNDERTAKER: John Zumbrick

ADDRESS: 20 o Pulaski

D 65274

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 65274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St., 4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Melvin A. Gotsch

(Residence in Baltimore: No. 531 N. Carlton St. Life St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

6-DATE OF BIRTH. Oct (Month) 9 (Day) 1901 (Year)

7-AGE. 20 yrs. 8 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Electric lineman
(b) General nature of industry, business, or establishment in which employed (or employer). Gas & Electric Co

9-BIRTHPLACE, (State or Country). Balto. City

PARENTS.

10-NAME OF FATHER. Frederick T. Gotsch

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Lucia A. Laughrey

13-BIRTHPLACE OF MOTHER, (State or Country). Balto city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick T. Gotsch

(Address) 531 N. Carlton St

15-Filed JUN 19 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull, fall with electric wire & Pole accident

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Hemorrhage ext. Brain

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) James M. Fenton M. D. (Coroner)

June 17 1922 (Address) 700 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death/ ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Loveland & Crawford ave

Former or usual residence. 531 N. Carlton St

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, June 19 1922

20-UNDERTAKER, W. T. Hartley — ADDRESS 815 N. Washington St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 65275

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 S. Ellwood Av. St. 1 WARD)

2-FULL NAME Samuel J. Robertson

(a) RESIDENCE. NO. 704 S. Ellwood AVE. WARD. 1

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Robertson

6 DATE OF BIRTH (month, day, and year) May 4 – 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63 y	—	—	

8 OCCUPATION OF DECEASED 062

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Beth. Ship. Bldg. Co.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) md (State or country) —

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant H. E. Burkins

(Address) 911 S. East. Ave

15 Filed JUN 19 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to June 16, 1922

that I last saw him alive on June 14, 1922

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. Avoy, M. D.

6/7, 1922 (Address) 829 S. Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION/REMOVAL White Hard Md DATE OF BURIAL June 20 1922

20 UNDERTAKER Jas. E. Miller ADDRESS 2334 Jeffer

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65276

D 65276

CERTIFICATE OF DEATH.

40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 23 WARD)

2-FULL NAME Beatrice Deal

(a) RESIDENCE NO. (907 Peach alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Husband Mills

11 BIRTHPLACE OF FATHER (city or town)
(State or country) No. Carolina

12 MAIDEN NAME OF MOTHER Virginia Mitchell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. Carolina

14 Informant Municipal Hospital
(Address)

15 Filed JUN 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17/22. 19

17

I HEREBY CERTIFY, That I attended deceased from 6/15/22. 19 to 6/17/22 19

that I last saw her alive on 6/17/22. 19

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Rt. tubo ovarian abscess (Surg)
JVR

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 3 ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Brennbock, M. D.

19 (Address) Baltimore Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 6/20/22

20 UNDERTAKER Robt. L. Parham

ADDRESS 220 W. Hamburg

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lewis

65277

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65277

CERTIFICATE OF DEATH.

4 X 177

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles Lewis

(Residence in Baltimore: No. Glen Arm Md St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Don't Know (Month) (Day) (Year)

7-AGE. 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer). 04

9-BIRTHPLACE, (State or Country). Don't Know

PARENTS.

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER, (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ena Hutchenreuter

(Address) Glen Arm Md

15- FILED JUN 19 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 17 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or)~~ Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, or)~~ Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride of Mercury Poisoning

(Duration) yrs. 2 mos. hours ds.

CONTRIBUTORY (Secondary) Don't Know whether he took this Accidentally or Intentionally

(Duration) yrs. mos. ds.

(Signed) H. R. Gorsuch M. D.

(Coroner.)

6-18 1922 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Glen Arm Md

19-PLACE OF BURIAL OR REMOVAL. Baltimore DATE OF BURIAL. June 19 1922

20-UNDERTAKER. Peter Nicolaus ADDRESS Easton Md

(If DEATH occurred in a hospital or institution, state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

D-65278 Spec. 6-9-19 M. 7-8-19—1000 Bks.

99-003 D 65278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Mt. Washington Hospital

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Manhatten Ave (St.) Stewart Ave (Ward) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances A Almy

(a) RESIDENCE. (No.) Manhatten Ave Stewart Ave (Ward.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Capt. Holden Almy

6 DATE OF BIRTH (month, day, and year) June 1 - 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER William B. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Louise Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Massachusetts

14 Informant (Address) Mrs. W. S. Almy Manhatten Ave Stewart Ave

15 Filed JUN 19 1922 . 19 ROBERT R. KRAMER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 1922, to June 18, 1922, that I last saw her alive on June 18, 1922, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac weakness due to age (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ordinary clinical

(Signed) S. R. Wantz M. D.

June 18, 1922 (Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portsmouth Va	June 19 1922
20 UNDERTAKER	ADDRESS
A. L. Marshall	3539 Falls Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65279

D 65279

91-002

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 E. Eager St. ST.: 7 WARD)

2-FULL NAME Mary Cox

(a) RESIDENCE. NO. 1628 E. Eager St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Cox

6 DATE OF BIRTH (month, day, and year) May 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER David Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Lanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant (Address) Mrs. Dawthrop 2829 Raynor

15 Filed JUN 19 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14th, 19 22, to June 17th, 19 22,

that I last saw h 8 alive on June 17th, 19 22,

and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Contributory Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos Stone, M. D.

June 19, 1922 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd.	June 1922
20 UNDERTAKER	ADDRESS
L. Frau McCully	130 S. Front

INFORMATION SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65280

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 415 Yale Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Ann Payne

(a) RESIDENCE. NO. 415 Yale Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred about 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman T. Payne

6 DATE OF BIRTH (month, day, and year) Oct 8 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Salina Pa.

PARENTS

10 NAME OF FATHER James Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salina Pa.

12 MAIDEN NAME OF MOTHER Nancy Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James T. Payne
(Address) 415 Yale Ave

15 Filed , 19 Robert T. Harrison
Registrar
Burial Permit Clerk

JUN 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1922, to June 18, 1922, that I last saw h[illegible] alive on June 18, 1922, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bradford Pa	June 20 1922

20 UNDERTAKER H. B. Wappert ADDRESS 2236 Frederick Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65281

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 1 W WARD)

2-FULL NAME Charles Allen

(a) RESIDENCE NO. 2217 Maryland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE: Years 48. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Do

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bayview Hospital Balto, Md

Filed 6/19/22 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1920 to June 16, 1922

that I last saw h living on June 15, 1922

and that death occurred, on the date stated above, at 7.00 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cataract

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith M. D.

4/19/1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 6/22 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65282

125769

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

D 65282

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST. 22 WARD)

2-FULL NAME William Chatman

(a) RESIDENCE NO. 117 York St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Chatman

6 DATE OF BIRTH (month, day, and year) July 20-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster shucker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Sandy Chatman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Lascue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, 10220 Burial Permit Clerk

JUN 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 1922, to June 11th, 1922, that I last saw him alive on June 11th, 1922, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic aortitis

Heart failure

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? 117 York St

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 JUN 9 1922

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65283

CERTIFICATE OF DEATH.

X 128

24

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles Steverson. (C)

(Residence in Baltimore: No. Sparrows Point. St.; en route. yrs., mos., ds.)

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 04

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Dawson L. Farber.

(Address) Sparrows Point.

15-

Filed..... 192.....

Registrar.

Robert F. Garrison, Deputy Health Clerk.

1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11th. 1922. (Month) (Day) (Year) 192.....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Brights Disease.

unknown.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edw. M. Reinhardt M. D. (Coroner.)

June 19 1922 (Address) 1917 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?..... Sparrows Point.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Tasley Va.	June 19 1922
20-UNDERTAKER.	ADDRESS
John F. Denny	715 Light St

D 65284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65284

CERTIFICATE OF DEATH.

170

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1804 Warden ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonio Tesoro (or Tsoro)

(Residence in Baltimore: No. 1804 Warden St.; 10 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, 2 (Month) 5 (Day) 1891 (Year)

7-AGE, 31 yrs. mos. ds. ~~If LESS than 1 day, hrs. or mts.?~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): yes

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Libertini

(Address) 1410-Ashland Ave

15- JUN 20 1922 ROBERT R. KRAUTER,

Filed ....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot through heart, with dementia prior

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D.
(Coroner.)

June 19, 1922 (Address) 1639 Division

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, 6/21, 1922

20-UNDERTAKER George J Ruth

ADDRESS 1735 Harford Av.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65285

CERTIFICATE OF DEATH.

101 / 001

D 65285

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 Ostobine ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Brooks

(a) RESIDENCE. No. 316 Ostobine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
24	24	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housework.

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): David Easter 916 Pacific ave

15 Filed JUN 20 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-1922

17 I HEREBY CERTIFY, That I attended deceased from June 12th, 1922, to June 16th, 1922, that I last saw h[illegible] alive on June 16th, 1922, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jas C Cayce, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: June 20 1922

20 UNDERTAKER: David Easter

ADDRESS: 916 Pacific

N. B.—WRITE P[illegible] mation s[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Young

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65286

CERTIFICATE OF DEATH.

D 65286

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Pearl st. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Henry Young

(Residence in Baltimore: No. 506 Pearl st. St.; 53 yrs. Not known mos. ds.)

Widowed

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Widowed

6-DATE OF BIRTH, Not known (Month) (Day), 1869 (Year)

7-AGE, 53 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dan'l Easter

(Address) 916 Druid

15- JUN 20 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 3 1922, to June 17 1922, that I saw him alive on June 17 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myo-carditis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastritis + General debility

(Duration) yrs. 1½ mos. ds.

(Signed) H. N. King M. D.

6-19, 1922 (Address) 6 S. Fr. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, June 20, 1922

20-UNDERTAKER Dan'l Easter

ADDRESS 916 Druid

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65237

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 65287

Registered No. C.....

City of BALTIMORE: (No. 633 Sterling St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Robt A. Richardson

(Residence in Baltimore: No. 633 Sterling St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Negro

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

6-DATE OF BIRTH. July 6 1850
(Month) (Day) (Year)

7-AGE. 71 yrs. 11 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Coal & Ice
(b) General nature of Industry, business, or establishment in which employed (or employer). Dealer

9-BIRTHPLACE, (State or Country). Westmoreland Co Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar Richardson

(Address) 633 Sterling St.

15-

Filed JUN 21 1922 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Stone M. D.
(Coroner.)

6-19 1922 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, June 21st 1922

20-UNDERTAKER. Thos J. G. Locke ADDRESS 1302 Jefferson

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Schock.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65288

CERTIFICATE OF DEATH.

162 D 65288

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3432 E. Lombard ST., 26 WARD)

2-FULL NAME Thelma Schock

(a) RESIDENCE NO. 3432 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. ½ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				6 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Gilbert Schock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Weber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md

14 Informant Gotlieb Schock
(Address) 3432 E. Lombard St

15 Filed JUN 21 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1922

17

I HEREBY CERTIFY, That I attended deceased from June 19 1922 to June 19 1922

that I last saw her alive on June 19 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

a Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Allen Bentham M. D.

6-19 1922 (Address) 3134 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	6/20 1922
20 UNDERTAKER Philip Henrig	ADDRESS 2016 Aliceanna

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65289

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 65289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Bay View St.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John S. Tenley

(Residence in Baltimore: No. 418 N. Eighth St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 1st (Day), 1872 (Year)

7-AGE, 50 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo. Tenley

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Sally O'Day

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie J. Tenley

(Address 410 N. Eutaw St.

15- FILED JUN 20 1922 ROBERT R. KRAUTER, Burial Permits Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 17th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Knife wound

(Duration) yrs. mos. ds.

(Signed) Thos B. Horton M. D.

June 19 1922 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or if death was VIOLENT, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 6/21, 1922

20-UNDERTAKER Philip Herrig — ADDRESS 2016 Orleans St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23 D 65290

D 65290

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2834 Guilford ave ST., 17 WARD)

2-FULL NAME Bertha Rossiter

(a) RESIDENCE NO. 2834 Guilford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of J. Ford Rossiter

6 DATE OF BIRTH (month, day, and year) August 8th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER William H. McElroy

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Wyrough

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant J. Ford Rossiter
(Address) 2834 Guilford ave

15 Filed JUN 20 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1922, to June 18th, 1922.
that I last saw her alive on June 12th 11:30 m 1922
and that death occurred, on the date stated above, at 11.10 a. m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis,

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Granville Bantz, M. D.

, 19 (Address) S.W. Cor. Calvert & Preston Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL June 21 1922

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E. Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65291

CERTIFICATE OF DEATH.

74 901 D 65291

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2302 Belair Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura M. Manley

(a) RESIDENCE NO. 2302 Belair Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Manley

6 DATE OF BIRTH (month, day, and year) Dec 5, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	59	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Manley

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Md~~ Md

12 MAIDEN NAME OF MOTHER Tobitha Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna Fulaut

(Address) 2302 Belair Ave

15 Filed JUN 20 1922 ROBERT R. KIMUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 18, 1922, that I last saw her alive on June 18, 1922, and that death occurred, on the date stated above, at 10 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral - Hemorrhage

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G. Owen M. D.

June 19 22 (Address) 35 E Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL June 21 1922

20 UNDERTAKER Lilly & Zile

ADDRESS 1038 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65292

CERTIFICATE OF DEATH.

37 D 65292

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tbc Hosp ST. 25 WARD)

2-FULL NAME Mary Boland

(a) RESIDENCE. NO. 140 Church ST., Violetville WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Latimer Boland

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years 77; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED — 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Fousch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Lingheart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Hosp. Records

15 Filed JUN 2 01922 ROBERT R. KRAUTER, Burial Permit Registrar Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 24 19 22, to June 17, 19 22, that I last saw her alive on June 17, 19 22, and that death occurred, on the date stated above, at 2-10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray & pos. sputum

(Signed) Frances L. Dadaglacco M. D.

. 19 (Address) Municipal Tbc Hosp

*State the Disease Causing Death. In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill

DATE OF BURIAL: June 20 1922

20 UNDERTAKER: Frank Crook Son

ADDRESS: 1906 Eutaw

James Smith

D 65293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 837 W. Saratoga St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Smith

(Residence in Baltimore: No. 837 W. Saratoga St. St. 13 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colrd

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) Don't Know (Day) ..... (Year)

7-AGE: 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): N. Carolina

PARENTS.

10-NAME OF FATHER: Larkis Smith

11-BIRTHPLACE OF FATHER, (State or Country): N. C.

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country): Don't Know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mazie Smith

(Address) 837 W. Saratoga St.

15- Filed JUN 20 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 17 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Jones M. D. (Coroner.)

June 19 1922 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	June 20 1922
20-UNDERTAKER	ADDRESS
Brown & Fleckenstein	114 W. [illegible] St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65294

CERTIFICATE OF DEATH.

23 D 65294

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

2-FULL NAME Edna Epps

(a) RESIDENCE No. 656 Raborg St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Windsor, Maryland

PARENTS

10 NAME OF FATHER: Edward Wrightman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,

(Address): Municipal Hospital.

15 JUN 20 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 19 22

17

I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to June 17, 1922, that I last saw her alive on June 17, 1922, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Mackay, M. D.

6/19/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenberry Cemetery

DATE OF BURIAL: June 20 1922

20 UNDERTAKER: R. C. Gross

ADDRESS: 1405 Mc Elderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65295 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65295

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1601 Pipler Street ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. ~~Lottie~~ Catherine E. Boone

(a) RESIDENCE. NO. 1601 Pipler Street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or WIFE of) John L. Boone

6 DATE OF BIRTH (month, day, and year) 1-25-1857

7 AGE: Years 65 Months 5 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vinton Co. Ohio

PARENTS

10 NAME OF FATHER William Barnhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vinton Co.?) Ohio

12 MAIDEN NAME OF MOTHER Sara Bennington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fayette Co. Penn

14 Informant (Address) Mrs Jennie E Little 1601 Pipler Street

15 Filed JUN 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1921, to June 18, 1922, that I last saw her alive on June 18, 1922, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about 5-10 (duration) yrs. mos. day

CONTRIBUTORY (Secondary) Myocarditis Chronic

3-5 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history and course of disease

(Signed) C. Winston Richards, M. D.

, 19 (Address) 2918 Brighton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park Cem. DATE OF BURIAL June 19 1922

20 UNDERTAKER Harry Mitzke ADDRESS Balto

MAKE ENTRIES WITH INK, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65296

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Roslyn ave ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Eleanore Brandt

(a) RESIDENCE NO. 517. N. Arlington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Brandt

6 DATE OF BIRTH (month, day, and year) Feb 9, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Wm. Lockington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Harry Ickler

(Address) 2804 Roslyn Ave

15 Filed JUN 20 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12th, 1922, to June 19th, 1922, that I last saw h. alive on June 19th, 1922, and that death occurred, on the date stated above, at 7.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy Paralysis agitans (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas Jones, M. D.

, 19 (Address) 2803 E. Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL June 22 1922

20 UNDERTAKER W. J. Ickler & Son ADDRESS Nor. Ave.

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 65297 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65297

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2429 N. Calvert ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James O Luke

(a) RESIDENCE NO. 2429 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily J. Luke

6 DATE OF BIRTH (month, day, and year) Oct 10 1826

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	95	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER McKeown

11 BIRTHPLACE OF FATHER (city or town) (State or country) McKeown

12 MAIDEN NAME OF MOTHER McKeown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) McKeown

14 Informant Albert Luke (Address) 2409 N Calvert St

15 JUN 2 01922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1922 to June 17, 1922

that I last saw him alive on June 17, 1922

and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

Chronic Interstitial nephritis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) John [illegible] M. D.

19 22 (Address) 1219 Poplar Grove

June 26

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL June 22 1922

20 UNDERTAKER W. L. Richardson

ADDRESS North Ave

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 65298 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 65298

CERTIFICATE OF DEATH. 179

1-PLACE OF DEATH Garrett Hospital for Children REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Harman

(a) RESIDENCE NO. 1760 Riverside Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 4, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Jno H. Harman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Emma M. Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Jno H. Harman 1760 Riverside Ave

15 Filed JUN 21 1922 19 ROBERT R. KRAUTER Burial Permit Clerk. Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to June 17, 1922, that I last saw her alive on June 16, 1922, and that death occurred, on the date stated above, at 1.20 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis - mitral insufficiency

Chorea -

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Charles Le Warnet, M. D.

, 19 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: June 20 1922

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. D 65299

1-PLACE OF DEATH Res. 49 Rockland Ave

City of BALTIMORE: (No. Gustin Gaddens St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Justis Gadding

(Residence in Baltimore: No. Res 49 Rockland Ave St.; yrs., mos., ds.) 12 Years

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Negro

5-Single, Married, Widowed or Divorced. (Write the word.) Married

6-DATE OF BIRTH, May (Month) 1 (Day) 1849 (Year)

7-AGE, 73 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) in Quarry

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Wm Geddens

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, Belinda White

13-BIRTHPLACE OF MOTHER, (State or Country). Hamilton Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife

(Address) R.D. 49 Rockland

15-

Filed JUN 20 1922 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 18 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Lesion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility, Rheumatism

(Duration) yrs. mos. ds.

(Signed) J. S. T. Bodine M. D. (Coroner.)

6 18 192 2 (Address) 508 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL, June 21 1922

20-UNDERTAKER, Wm Robert A Elliott ADDRESS 1725 Ashland Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65300 — 179 vD 65300

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Marshall ST., 23 WARD)

2-FULL NAME George C. Walters

(a) RESIDENCE NO. 1606 Marshall ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ophelia Walters

6 DATE OF BIRTH (month, day, and year) July 24-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheetiron worker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer Dixon Manufg Co

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ophetia Walters
(Address) 1606 Marshall st

15 Filed JUN 20 1922, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 19, 1922
that I last saw h~~e~~ alive on June 8, 1922
and that death occurred, on the date stated above, at 1-30 ~~P~~ A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. S. T. Campbell M. D.

June 19, 1922 (Address) 1644 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 21 1922
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

mation should be carefully supplied. Any wrong or illegible statement CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 65301

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Pat. Pk. Ave ST., 6 WARD)

2-FULL NAME Philomina C. Schelle

(a) RESIDENCE NO. 414 N. Pat. Pk. Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of late Peter S. Schelle

6 DATE OF BIRTH (month, day, and year) Oct 31-48

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	73	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Busch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. Schelle

(Address) 414 N. Pat Pk. Av.

15 Filed JUN 20 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to June 19, 1922, that I last saw h— alive on June 18, 1922, and that death occurred, on the date stated above, at 3-30 A m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. P. Neer, M. D.

6/20/1922 (Address) 408 S Pat Pk Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 6/22 1922

20 UNDERTAKER Philip Herwig — ADDRESS 2116 Aisquith

information should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 65338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65302

CERTIFICATE OF DEATH.

113 D 65302

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 7 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Herman Mahla

(a) RESIDENCE NO. 526 N. Decker Ave. (St.) WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) 0 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Geo. Mahla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 20 1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4th 1922 to June 20th 1922

that I last saw h alive on June 20th 1922

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

6/20, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 6/22 1922

20 UNDERTAKER Philip Henry

ADDRESS 2016 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65303 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 3 / D 65303

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Naylor

(a) RESIDENCE. No. ~~11th and Lombard sts.~~ 621 S. 14½ St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Cat Naylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Mary Highe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Hospital Records

(Address) M.T.H.

Filed JUN 20 1922

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 19, 1922, that I last saw him alive on June 19, 1922, and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalyglesh M. D.

6-19-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwatka Cem	6/21 1922
20 UNDERTAKER Philip Henry	ADDRESS 2016 Eden ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65304

CERTIFICATE OF DEATH.

161-D 65304

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes ST., 12th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Renner

(a) RESIDENCE NO. Bishop Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Br.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 6-16-1922

7 AGE: Years: 1 day; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Agnes Hospital

PARENTS

10 NAME OF FATHER: Chas. Renner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Mr. Chas Renner

(Address): Bishop Lane

15 JUN 2 01922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-16 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-16, 1922, to 6-16, 1922.

that I last saw h[illegible] alive on 6-16, 1922.

and that death occurred, on the date stated above, at P.M. m.

The CAUSE OF DEATH* was as follows:

Premature baby 6½ months old. Died of respiratory failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. H. Scott M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: June 20 1922

20 UNDERTAKER: John F. Cowan & Son

ADDRESS: per Fallon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65305

CERTIFICATE OF DEATH.

161 001 D 65305

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 915 Morris ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Oliver Cregiles

(a) RESIDENCE. NO. 915 Morris ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 22

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Oliver Cregiles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anita Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Daisey Jones
(Address) 346 Cathedral St

15 Filed 1922 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 19 22 to June 17, 19 22

that I last saw him alive on June 17, 19 22,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Not Known. Born 2 PM Died 7 PM Delivered by Midwife 7½ Months (duration) Foetus mos. ds.

CONTRIBUTORY (Secondary) Mrs. Murray 902 N. Eutaw

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel A Bair, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 20 1922
20 UNDERTAKER David Kemsley	ADDRESS 627 Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 65306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65306

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1414 N. Parrish Ln St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Lizzie Foor

(Residence in Baltimore: No. 1414 N. Parrish Ln St.; 10 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	single

6-DATE OF BIRTH. about (Month) (Day) 1894 (Year)

7-AGE. 28 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Foor

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Maggie Dorsey

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. Foor

(Address) 1414 N. Parrish Ln

15- Robert P. Harrison,

Filed ..... 192.....

1922 Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 18 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. J. Hennessy M. D. (Coroner.)

June 19 1922 (Address) 210 E. Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL. Thursday June 22 1922

20-UNDERTAKER. James H. Deems & Grandson ADDRESS 1303

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

72

Spec.—1-10-21—M&T—1500 Bks.

D 65307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65307

CERTIFICATE OF DEATH.

60-007

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3503 Fairview Ave ST. 45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Garrett

(a) RESIDENCE NO. Washington D.C. ST., WARD Washington D.C.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Govt Printing Office

9 BIRTHPLACE (city or town) Washington DC
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Garrett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ky

12 MAIDEN NAME OF MOTHER Julia A Hardisty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Lillian M. Earnshaw
(Address) 3523 Fairview Ave

15 Filed , 19 Registrar

2 0 1922

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 8, 19 22, to June 20 19 22
that I last saw h alive on June 19 19 22
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Hypostatic Pneumonia

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Hyper-thyroid
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Simmons M. D.

June 20 19 22 (Address) 4 W Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL June 22 19 22

20 UNDERTAKER Wm Tickner & Sons ADDRESS North Pa

mation should be entirely supplied. Any blanks not properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65308

38 D 65308

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No.) ..... ST., 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Carboni

(a) RESIDENCE NO. 211 Aisquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Carboni

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: about 68 Years ..... Months ..... Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone cutter

(b) General nature of industry, business, or establishment in which employed (or employer): 075

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Louis Carboni

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant: Hospital Records
(Address) .....

15 Filed ..... 1922, 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/19/22 19

17 I HEREBY CERTIFY, That I attended deceased from 6/16/22, 19 ..... to 6/19/22 19 ....., that I last saw h[illegible] alive on 6/19/22, 19 ....., and that death occurred, on the date stated above, at 9 15 9 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) 30 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (or Incidental) Chronic nephritis (duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 6/21/22 19

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1738 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65309 D 65309 D 65309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 St. Paul ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Ann Reed

(Residence in Baltimore: No. 1624 St. Paul St. 9/ yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: Unknown (Month), 1851 (Day) (Year)

7-AGE: 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): ------

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Livington M. Bennett.

11-BIRTHPLACE OF FATHER (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Eve Ann Yundt

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace E. Reed.
I624 St. Paul St.
(Address)

15-

Filed JUN 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1919, to June 19 1922, that I saw h[er] alive on June 2 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. 4 mos. 1 ds.

(Signed) Frank M. Burke M. D.

June 19, 1922 (Address) 2435 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery

DATE OF BURIAL, June 21, 1922

20-UNDERTAKER William Cook

ADDRESS 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65310

CERTIFICATE OF DEATH.

161-001

D 65310

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 510 Light ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME "Infant" Blumenstein

(Residence in Baltimore: No. 510 Light St St.; yrs., mos. ½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 19 (Day), 1922 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 8 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Louis Blumenstein

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Regina Schorn

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Krauss

(Address) 1439 Balto St

15-

Filed JUN 21 1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 19 1922, to June 20 1922, that I saw him alive on June 19 1922, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonary

8th month of Gestation

(Duration) ..... yrs. ..... mos. 8 hours ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ..... yrs. ..... mos. 8 hours ds.

(Signed) Jason H. Goldman M. D.

June 20, 1922 (Address) 1516 West St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Rosedale — DATE OF BURIAL, June 22, 1922

20-UNDERTAKER Jack Krauss — ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item of information is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65311

CERTIFICATE OF DEATH.

93 D 65311

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwika Karaban

(a) RESIDENCE NO. 409 S. Chester St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address) Municipal Hospital.

15 Filed JUN 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1922, to June 19, 1922, that I last saw h ex alive on June 19, 1922, and that death occurred, on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:

Infected varicose leg ulcer (left) Senility

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) L. H. Bumbaker M. D.

6/20/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	June 22, 1922.
20 UNDERTAKER W. F. Laskowski	ADDRESS 905 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Ciegelski ✓

D 65312

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

101 D 65312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 Sherman St ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. V. Ciegelski

(a) RESIDENCE NO. 330 S Sherman St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs 4 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17- 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) Balt (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Ciegelski

11 BIRTHPLACE OF FATHER (city or town) Balt. (State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie A Burchers

13 BIRTHPLACE OF MOTHER (city or town) Balt. Md. (State or country)

14 Informant Thomas Ciegielski (Address) 330 S Sherman St.

15 JUN 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21. 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 20 1922, to June 20 1922, that I last saw h alive on June 20 1922, and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows: .

Lobar Pneumonia

2 days (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriology

(Signed) Samuel Fineman, M. D.

, 19 (Address) 332 S. Pats Parkway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL June 22 1922.

20 UNDERTAKER W. J. Sadowski. ADDRESS 705 S Sum St

Nation should be currently supplied. Any means of which CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65313

CERTIFICATE OF DEATH.

129 D 65313

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., 8 WARD)

2-FULL NAME Inna Anna Williams

(a) RESIDENCE NO. 1914 Washington ST., — WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Williams

6 DATE OF BIRTH (month, day, and year) May 4th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Nicklaus Stenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John F. Williams

(Address) 1914 E. Washington St.

15 Filed JUN 21 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922. to June 19, 1922.

that I last saw h[e] alive on June 19, 1922.

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Mit Anemia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fatal Bladder disease

(duration) yrs. mos. 12. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of June 16-22

Was there an autopsy? No.

What test confirmed diagnosis? P. S. + S. —

(Signed) Harold C. Pulsbury, M. D.

19 (Address) 410 Cedarcroft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 22 1922

20 UNDERTAKER Frank A. Fink — ADDRESS 910 N. Gay St.

Modo ✓

Spec.—1-10-21—M&T—1500 Bks.

15 R 05314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65314

113

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3 WARD)

2-FULL NAME Mary Modo

(a) RESIDENCE NO. 919 Fawn St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 25-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	—	—	4 Weeks	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Kadion Modo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Kidion Malay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to June 20, 1922, that I last saw her alive on June 20, 1922, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) ..... yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) Abscess of breast

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of (abscess opened) June 2 1922

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Horace G. Stewart, M. D.

6/21, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL June 21 1922

20 UNDERTAKER Peter Nicolaus — ADDRESS Eastern Av

IMPORTANT should be carefully written, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 65315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 187

CITY OF BALTIMORE (No. Foot of Broadway ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roman Forcak

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.) Not Known

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Single

6-DATE OF BIRTH, Unknown 1 (Month) (Day) (Year)

7-AGE, about 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... 087

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- JUN 21 1922, 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning — Supposed to be Accidental

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Thos. J. Norton (Coroner) M. D.

June 20 1922 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	6/21, 1922
20-UNDERTAKER	ADDRESS
Weber Fial Kraus &	409 S. Bond St.

N. B.—Every item of information should be carefully supplied. Any doubtful answer should be followed by a question mark. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-0-19—H. P. Co.—1000 Bks.

D 65316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland general Hospital

CITY OF BALTIMORE: (No. 24 ST.; 1 WARD)

REGISTERED No. 118-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Roemer

(a) RESIDENCE. No. 116 E. Randall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 0 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence M. Roemer

6 DATE OF BIRTH (month, day, and year): June 3 1866

7 AGE — Years: 56 Months: 0 Days: 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer): Pol

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: J. H. Roemer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Petch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Wm Roemer Randall St

15 Filed JUN 21 1922, 19

ROBERT P. KRAUTZ Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/20 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 1922, to 6/20, 1922,

that I last saw h[illegible] alive on 6/20, 1922,

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

adhesions Duodenal obstruction

(cardiac decompensation)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 116 E Randall St

Did an operation precede death? yes Date of 6/20/22

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. D. Smith, M. D.

, 19 (Address) Maryland General

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London PK Cem — DATE OF BURIAL: 6/23 1922

20 UNDERTAKER: I. Fenn McCully — ADDRESS: 130 E. Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65317 — 185 — D 65317

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. St. Josephs Hos. St., 205 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thomas E. Kirby

(Residence in Baltimore: No. Masonville ~~Apts~~ St.; 22 yrs., 4 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White	Married

6-DATE OF BIRTH. Feb. 14 1900
(Month) (Day) (Year)

7-AGE. 22 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter 650
(b) General nature of Industry, business, or establishment in which employed (or employer). Davidson Chem

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Wm. F. Kirby

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Sophia Silas

13-BIRTHPLACE OF MOTHER, (State or Country). Balto and.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. F. Kirby

(Address) 900 Patapsco Ave Bowly

15- JUN 21 1922

ROBERT R. KRAMER.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 19 1922
1:30 am. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
accidental death - Shock,
fell from racer dip at Riverview Park 8:30 PM 6-18-22
(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) J. S. Gallagher (over)
(Duration) 3 yrs. .... mos. .... ds.

(Signed) J. S. Gallagher M. D.
(Coroner.)
6-19 1922 (Address) 548 E. Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	6/22 1922

20-UNDERTAKER.	ADDRESS
J. Frew McCully	130 E. Fort.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mash

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65318

CERTIFICATE OF DEATH.

46

D 65318

REGISTERED NO.

1-PLACE OF DEATH House of the Dead Shepherd

CITY OF BALTIMORE: (No. Mount & Collins. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Magdalen St. Margaret Mary Nash

Mount & Collins

(a) RESIDENCE. No. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Nash.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Keefe

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Sister Mary Dolores (Address) Home of the Dead Shepherd

15 Filed JUN 21 1922 ROBERT H. KRAUSER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th 1922

17

I HEREBY CERTIFY, That I attended deceased from June, 1919, to June 20th, 1919, that I last saw her alive on June 19th, 1919, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gross symptoms & signs

(Signed) John Chatard, M. D.

June 20th 1922 (Address) 40 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	6/21/22
20 UNDERTAKER	ADDRESS
John F. Doherty & Sons	1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65319

D 65319

CERTIFICATE OF DEATH

58-001

1-PLACE OF DEATH Howard A Kelly Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. (1418 Eutaw Place) ST.: 27 WARD)

2-FULL NAME Harney Middlekauff

(a) RESIDENCE. NO. 7 Carlin Ave. Hamilton ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rena Middlekauff

6 DATE OF BIRTH (month, day, and year) March 27th 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Howard A. Kelly Hospital

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Denton Middlekauff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Rena Middlekauff

(Address) 7 Carlin Ave. Hamilton

15 Filed JUN 21 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from November, 1921 to June 20, 1922

that I last saw him alive on June 20, 1922,

and that death occurred, on the date stated above, at 11.05 P m.

The CAUSE OF DEATH* was as follows:

Aplastic Anaemia

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Septicaemia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood

(Signed) Guy N. Cromwell, M. D.

6/20 1922 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	June 23 1922
20 UNDERTAKER	ADDRESS
Wilbur W. Shivers	1018 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of occupation must be complete. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pernicious anemia. Transfusion about a week ago. Not cancerous. Cause of septicaemia not known

D 65320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18V D 65320

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Penna. R.R. Pier Lower Canton ST. ARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Paul Becker.

(Residence in Baltimore: No. 713 S. Clinton St. 6 yrs., 11 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 5th (Day), 1915. (Year)

7-AGE, 6 yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Paul Frederick Becker.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Adelaide Miller.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Frederick Becker.

(Address) 713 S. Clinton St.

15-

FILED JUN 21 1922 19.. GG

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 19th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fell off Pier

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. R. Norton M. D.

June 20th, 1922 (Coroner) (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, June 22 1922

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65321

X.84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wolfe Weidenbaum

(a) RESIDENCE NO. 771 S. 14th St. Newark N.J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Anna Weidenbaum

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	44?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ralph Weidenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21- 1922

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1922, to June 21, 1922

that I last saw him alive on June 21, 1922

and that death occurred, on the date stated above, at 8 30/a.m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N.Y. City

Did an operation precede death? Yes Date of June 20 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Warfield M Firor, M. D.

6/21 1922 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York

DATE OF BURIAL 6/21 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65322

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 801 D 65322

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 115 a/s South Street

CITY OF BALTIMORE: (No. Hebrew aged Home ST., 7 WARD)

2-FULL NAME Harris Cohen

(a) RESIDENCE NO. 1703 E. Madison St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Cohen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer) 1080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Abraham Lewis Jack Lewis 1912 E Federal St

15 FILED JUN 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 20, 1922

that I last saw him alive on June 20, 1922

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

DVN

General paralysis

(duration) ... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W J Baylis, M. D.

6/21 1922 (Address) 210 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 6/21 1922

20 UNDERTAKER Jack Lewis 1439 Eden St

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65323

CERTIFICATE OF DEATH.

113 D 65323

REGISTERED NO.

1-PLACE OF DEATH St Vincents Infl Asy.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1401 Division ST., 14 WARD)

2-FULL NAME Albert Skillman

(a) RESIDENCE NO. 1401 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 400

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Vincents Infl Asy.

PARENTS

10 NAME OF FATHER John H. Skillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Mary Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant (Address) St Vincent Infl Asylum St & Bunting Ave

15 Filed JUN 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1922, to June 20, 1922, that I last saw him alive on June 20, 1922, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Chas. K. Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: June 20 1922

20 UNDERTAKER: Hamilton Funeral Home ADDRESS: 1507 N. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro intestinal disturbance

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 65324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65324

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3637 Chestnut Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frelon Gruffin Mrs Hyacinth Heage

(a) RESIDENCE. No. 3337 Chestnut Ave ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Mulatto	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Md - Jones

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Hyacinth Heage

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Hyacinth Heage
(Address) 3337 Chestnut Ave

15 Filed Robert F. Harrison, Registrar
6 21 1922
Burial Permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922 to June 19, 1922, that I last saw h[illegible] alive on June 19, 1922 and that death occurred, on the date stated above, at 1. A. m.

The CAUSE OF DEATH* was as follows:

Premature birth - Sixth month
(Cause not known)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) R B Johnson M. D.

6.19.1922 (Address) 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Interred in [illegible] Cemetery	19

20 UNDERTAKER Gilbert to take Charge of body ADDRESS 6/21/1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65325

CERTIFICATE OF DEATH.

10

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Sydenham Hospital ST., (WARD)

2-FULL NAME Thelma Reichert.

(a) RESIDENCE. NO. 212 S. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 26-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Charles Reichert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Carrie Dunkerly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Charles Reichert
(Address) 212 S. Carey st.

15 Filed Jun 21 1922 Robert P. Harrison, Registrar

Burial Permit Ward.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to June 21, 1922, that I last saw her alive on June 21, 1922, and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures positive

(Signed) Bela Gordon M. D.

6/21/22 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 21 1922
20 UNDERTAKER	ADDRESS
Jos. B Cook	1003 W. Balto st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65326

D 65326

162

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hosp ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME June Bella Kinnamon

(a) RESIDENCE. No. 2724 Harford ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 6-1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5 "	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md. General Hosp Balto Md

PARENTS

10 NAME OF FATHER Harry A Kinnamon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary A. Kinnamon

(Address) 2724 Harford ave.

15 Robt. P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21- 1922

17

I HEREBY CERTIFY, That I attended deceased from June 16th, 1922, to June 21 -, 1922, that I last saw h er alive on June 21, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. Asshpheim, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tillmans Island Md	June 21 1922
20 UNDERTAKER W M Routson	ADDRESS 2238 N Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 21 1922

Spec.—1-10-21—M&T—1500 Bks.

D 65327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65327

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 W 40 St, ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda M Yingling

(a) RESIDENCE NO. 1016 W 40 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Yingling

6 DATE OF BIRTH (month, day, and year) Aug 21 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm R Corbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia A Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm H Yingling

(Address) 1016 W 40 St

15 JUN 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1922, to June 19, 1922,

that I last saw h alive on June 19, 1922,

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Davies, M. D.

6/19, 1922 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL June 22 1922

20 UNDERTAKER Cheswoldt Son — ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65328 32

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 17 WARD)

2-FULL NAME Daniel R Morris

(a) RESIDENCE No. 2704 Bernard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 19th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Morris

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Blythe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUN 22 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19th 1922 to June 20th 1922, that I last saw h alive on June 20th 1922, and that death occurred, on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis —

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) None —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes Lumbar puncture

What test confirmed diagnosis?

(Signed) T B Gay, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 22 1922

20 UNDERTAKER Ehrenwerth Son & Co — ADDRESS Cheatinge

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65329

D 65329

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2072 Woodberry ave St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura E Sullivan

(a) RESIDENCE NO. 2072 Woodberry ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E Sullivan

6 DATE OF BIRTH (month, day, and year) Oct 10 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Oliver Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James E Sullivan

(Address) 2072 Woodberry ave

15 Filed JUN 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to June 20, 1922, and last saw h alive on June 20, 1922, and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema of the Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Thomson M. D.

, 19 (Address) 3692 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL June 23, 22

20 UNDERTAKER Cranwell & Son — ADDRESS Chestnut Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65330

D 65330

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S Twelth Street ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Killman

(a) RESIDENCE. No. 408 S Twelth Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Killman

6 DATE OF BIRTH (month, day, and year) Aug 20 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Cymanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sophia Kilman
(Address) 408 S Twelth Street

15 Filed JUN 22 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to June 20, 1922

that I last saw him alive on June 18th, 1922,

and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

40 nw
Senility age 71-10

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Brights disease indefinite

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Ford, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Road	June 23 1922
20 UNDERTAKER	ADDRESS
JOHN M WEBER	1803 Bank Street

mation should be carefully supplied. And should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 65331

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 65331

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 828 So. Bond ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Bednarczyk

(Residence in Baltimore: No. 828 So. Bond St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, Nov (Month) 19 (Day), 1921 (Year)

7-AGE, — yrs. 7 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...000...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Bednarczyk

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Zengoba

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Bednarczyk

(Address) 828 So. Bond St

15- Filed JUN 22 1922 ROBERT R. KNAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 21st (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchо-Pneumonia

(Duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) .....(Duration)....yrs....mos....ds.

(Signed) Thos. J. Horton M. D. (Coroner)

June 22 1922 (Address) Curtis Bay Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, ..., 19....

20-UNDERTAKER JOHN M WEBER — ADDRESS 1803 Bank Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65332 ✓ 43 D 65332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Robinson

(a) RESIDENCE No. 1739 McCullough St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	~~Unknown~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Waiter~~ Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 504

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Adam Robinson

11 BIRTHPLACE OF FATHER (city or town) New Orleans (State or country) La ~~Virginia~~

12 MAIDEN NAME OF MOTHER ~~Unknown~~ Laura Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital.

15 FILED JUN 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to June 20, 1922, that I last saw him alive on June 19, 1922, and that death occurred, on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma of tongue

(duration) yrs. 6? mos ds.

CONTRIBUTORY (Secondary) Metastasis to neck ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Brunbock, M. D.

6/20/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL June 23 1922

20 UNDERTAKER Samuel Hemsley

ADDRESS 537 N Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65333 — 179 — D 65333

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2552 Hollins St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Michael Brandel

(Residence in Baltimore: No. 2552 Hollins St.; yrs. 40 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. April (Month) 9 (Day) 1877 (Year)

7-AGE. 45 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... Brewer 086
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Brandel

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Brandel

(Address) 2552 Hollins st

15- Filed JUN 22 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

about (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Dilated heart (Duration) 1 yrs. mos. ds.

(Signed) James M. Fenton M. D. (Coroner.)

June 21 1922 (Address) 700 E Eden st

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer — DATE OF BURIAL. June 24 1922

UNDERTAKER. F. B. Wippert — ADDRESS 2236 Eutaw

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of death is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65334 — 18-002 — D 65334

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Homewood Hospital ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Johnson

(Residence in Baltimore: No. 5645 Gorsuch Grove ave St.; yrs. Evans alley 2 yrs mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Nov (Month) 17 (Day) 1855 (Year)

7-AGE, 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robt Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Maria Buckner

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Johnson
(Address) 5645 Gorsuch ave

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 23d (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows*
Injuries received by street car accident
Accidental
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
(Coroner.)
June 23 191 2 (Address) 7632 Belair Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Prospect Cem. DATE OF BURIAL, June 25, 1922

20-UNDERTAKER E. A. Medefield Jr ADDRESS 501 E 22 St

N. B.—Every item of information should be carefully supplied. Avoid using the figures 0 (cipher). Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65335

CERTIFICATE OF DEATH.

8 17 D 65335 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hosp St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Fox

(Residence in Baltimore: No. 2428 E Fayette Ave St.; yrs. 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH, Apr 12 1865
(Month) (Day) (Year)

7-AGE, 57 yrs. 2 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baggage M
(b) General nature of industry, business, or establishment in which employed (or employer) Am. Exp Co

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Conntry), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Fox (wife)

(Address) 2428 E Fayette

15- Filed JUN 22 1922 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20 192 2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Cut throat with carving Knife. June 16/22 Served Pt. Inquest Verdict

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Stock Inv of Blood

(Duration) yrs. mos. ds.

(Signed) J. S. H. Patterson M. D.
(Coroner.)

6-21 192 2 (Address) 508 E Northern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Cemetery DATE OF BURIAL, June 23 192 2

20-UNDERTAKER, Geo. Weber ADDRESS 2503 Edmondson

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of conditions is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65336

CERTIFICATE OF DEATH.

90 D 65336

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 725 Waesche ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Adams

(Residence in Baltimore: No. 725 Waesche St.; 27 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Dec 31, 1870
(Month) (Day) (Year)

7-AGE, 51 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress Own
(b) General nature of industry, business, or establishment in which employed (or employer): Laundress at Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Isaac Smith

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), do.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph S. Adams.

(Address) 725 Waesche St.

15- Filed JUN 22 1922, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16th 1922, to June 20th 1922, that I saw her alive on June 20th 1922, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Hortician Hemiplegia (Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

..... (Duration) — yrs. — mos. 7 ds.

(Signed) Edward E. Mackenzie M. D.

June 21, 1922 (Address) 1339 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, 6-23-, 1922

20-UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

Directions for preparing this certificate will be found on back. See instructions on back of certificate. important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65337

CERTIFICATE OF DEATH.

74-001

74 D 65337

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 N. Central Ave. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. H. Bornhorn.

(a) RESIDENCE NO. 1216 N. Central Ave. ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. -- mos. --- ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary. P. Bornhorn

6 DATE OF BIRTH (month, day, and year) Feb.-27-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cigarmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John. H. Bornhorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary. P. Bornhorn

(Address) 1216 N. Central Ave

15 FILED JUN 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-21-1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1920, to June 21, 1922,

that I last saw h[illegible] alive on June 21, 1922,

and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Cerebral

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

June 22, 1922 (Address) 1501 E Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June-24-1922

20 UNDERTAKER Henry Storck Son ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65338

D 65338

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N Monroe ST., 16 WARD)

2-FULL NAME Sadie Eugenia Wertzer

(a) RESIDENCE NO. 807 N Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard F Wertzer

6 DATE OF BIRTH (month, day, and year) ~~June~~ Nov 21 92

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER Geo A Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md.

14 Informant Bernard F Wertzer (Address) 807 N Monroe

15 JUN 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 14th, 1922, to June 21st, 1922, that I last saw her alive on June 20th, 1922, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows: Hysterectomy for fibroma 2/15/22. In hospital 7 weeks accpt. 7 probable embolic pneumonia. No pneumonia no T.B. found. Went to country soon after leaving hospital. Had hemorrhage (pulmonary) last week. Called to city with temp. 104°, physical signs of pneumonia not found.

CONTRIBUTORY (Secondary) Diag.—Pulmonary tuberculosis. Duration (duration) 2 to 3 months.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? See above.

Was there an autopsy? No.

What test confirmed diagnosis? Pulmonary tumor.

(Signed) O. St. Hoffman, M. D.

, 19 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL June 23 1922

20 UNDERTAKER W. M. Rouzer — ADDRESS 223 E. Lexington

Spec.—1-10-21—M&T—1500 Bks.

McCorkle ✓

D 65339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 McCulloh ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie A. McCorkle

(a) RESIDENCE NO. 1214 McCulloh ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 15-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic service

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Samuel R. McCorkle

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Sarah Beatty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Lila McCorkle

(Address) 1214 McCulloh Street

15 Filed JUN 22 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit No. .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to June 20, 1922, that I last saw h EV alive on June 18, 1922, and that death occurred, on the date stated above, at 10:20 a m.

The CAUSE OF DEATH* was as follows:

Stomach Exhaustion

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) ..... yrs. 15 mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) John H. Tompkins, M. D.

6/21, 19 22 (Address) 1017 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: June 22 1922

20 UNDERTAKER: Jno. M. Johnson

ADDRESS 1214 Calhoun St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65340 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65340

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH E. 6 WARD

CITY OF BALTIMORE: (No. 2213 Fairmount Ave ST.,

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris L. Wolpert.

(a) RESIDENCE No. 2213 Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? 9 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Wm~~ Einhorn

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 67 yrs. Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Samuel Wolpert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jonas Wolpert (Address) 2213 Fairmount Ave

15 Filed JUN 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to June 22, 1922, that I last saw h[illegible] alive on June 22, 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of oesophagus

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): oedema of lungs

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? clinical

(Signed) M J Baylin M. D.

6/22 1922 (Address) 210 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Sonthern ave DATE OF BURIAL: June 22 1922

20 UNDERTAKER: M of Feinberg ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dalesicky

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65341

CERTIFICATE OF DEATH.

90

D 65341

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 E Eager ST.: 7 WARD)

2-FULL NAME Vaclav Dalesicky

(a) RESIDENCE. NO. 2009 E Eager st ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? 15 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Dalesicky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Dalesicky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Milachov

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Frances Dalesicky 2009 E Eager st

15 Filed JUN 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1. 1922 to June 20. 1922

that I last saw him alive on " " 1922, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) ..... M. D.

, 19 (Address) 600 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	June 23 1922
20 UNDERTAKER	ADDRESS
Frank Evans & Son	1806 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST.: 7 WARD) 161

REGISTERED NO. D 65342

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McNeare

(a) RESIDENCE. No. ~~839 N Milton Av~~ ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/21/22

7 AGE: Years | Months | Days | If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles McNeare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Naomi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md

14 Informant Charles McNeare
(Address) 839 N Milton Av

15 Filed JUN 22 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from 10 am 6/21/22, 19 , to 3.20 PM 6/21, 19 22,

that I last saw her alive on 6/21, 19 22,

and that death occurred, on the date stated above, at 3 AM PM.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Miscarriage of 6 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edelman, M. D.

6/22, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 22, 1922

20 UNDERTAKER: Paul X Brockton — ADDRESS: 1106 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65343

CERTIFICATE OF DEATH.

49 D 65343

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Jefferson St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. H. Bailey

(a) RESIDENCE. NO. 1421 Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Ida Bailey

6 DATE OF BIRTH (month, day, and year) March 1st 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jenkins Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida Bailey
(Address) 1421 Jefferson

15 Filed ....., 19.... Robert P. Harrison, Registrar

JUL 22 1922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to June 20, 1922, that I last saw him alive on June 20, 1922, and that death occurred, on the date stated above, at 7.05 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Hoffman, M. D.

6-21-22 (Address) 1729 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woburn	June 25 1922
20 UNDERTAKER Chas. H. Elsey Co.	ADDRESS 1600 Mosher

HEALTH DEPARTMENT–CITY OF BALTIMORE

D 65344

CERTIFICATE OF DEATH

57 D 65344

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 518 Hanover St. 22 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lafayette Stewart

(Residence in Baltimore: No. 518 Hanover St. St.: 2 yrs. mos. ds.)

B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Not Known (Month), 1 (Day), (Year)

7 AGE: 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (State or country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas Stewart

(Address) 518 Hanover St

15 Filed , 191 Robert P. Harrison, Registrar
Burial Permit Clerk.

6 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 21 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to June 21, 1922, that I saw h[illegible] alive on June 21, 1922, and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

Duration yrs. 2 mos. ds

Contributory (SECONDARY) Senile Kidney Duration yrs. 2 mos. ds.

(Signed) T. Henry Bickell M. D.

(Address) 1203 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery A.A.Co. DATE OF BURIAL: June 23, 1922

20 UNDERTAKER: John F. Denny ADDRESS: 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65345

CERTIFICATE OF DEATH.

179 D 65345

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1833 Stoddard ST., 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Stubbs Pendleton

(a) RESIDENCE NO. 1833 Stoddard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pendleton

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Robert E. Harrison, 1616 E. ...

15 ... 19 ... Registrar

Burial Permit Clerk.

JUN 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1922 to June 20, 1922

that I last saw h[illegible] alive on June 17, 1922

and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH* was as follows:

Uremia (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 5 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Tomkins M. D.

6/7, 1922 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MW	June 23, 2
20 UNDERTAKER Lumber [illegible] Undertaking Co	ADDRESS 966 [illegible] Ave

mation should be carefully supplied. Note: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65346

CERTIFICATE OF DEATH.

90 D 65346

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Nell

(a) RESIDENCE NO. 954 Walnut ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O H D

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country)

14 Informant David Carter (Address) 946 Pierce

15 Robert E. Gibson, Registrar

N 22 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922, to June 21, 1922, that I last saw him alive on June 21, 1922 and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. j mos. 14 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S. S. & S.

(Signed) J. C. Schenuich, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 3 1922

20 UNDERTAKER [illegible] ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 65347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65347

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1740 E Balto St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary E Carroll

(Residence in Baltimore: No. 1740 E Balto St. 20 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, June (Month) 9 (Day) 1846 (Year)

7-AGE, 76 yrs. mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Goshen N J

PARENTS.

10-NAME OF FATHER, Warren Van Gilder

11-BIRTHPLACE OF FATHER, (State or Country). N. J.

12-MAIDEN NAME OF MOTHER, Emily Cameron

13-BIRTHPLACE OF MOTHER, (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Carroll (Son)

(Address) 1740 E Balto St

15-

Filed..... 192.....

Robert F. Harrison, Registrar.

Daniel Farrell, Clerk.

6 22 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 21 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental — Burned over entire surface of body

Her clothing caught fire from Gas Stove,

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. H. Patterson M. D. (Coroner.)

6-22 192.2 (Address) 542 E Fort Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
South Dennisville N J June 24 1922

20-UNDERTAKER. ADDRESS
H E Hughes 424 N. Bway

State CAUSE OF DEATH in plain terms, so that it may be properly classified. It is very important. See instructions on back of certificate.

D 65348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65348

CERTIFICATE OF DEATH.

1893 1893

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp, St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P. Mc Donnell

(Residence in Baltimore: No. 1021 Valley St (St.; yrs., 3 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

6-DATE OF BIRTH, July (Month) 2 (Day) 1918 (Year)

7-AGE, 3 yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael J. McDonnell

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Juliet O'Brien

13-BIRTHPLACE OF MOTHER, (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael J. McDonnell

(Address) 1021 Valley st. City

15-

Filed..... 192..... Registrar.

Robert F. Harrison, Assistant Board Clerk.

2 2 1922 3 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

accidental - Hit by Auto - Fractured Skull

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Potter M. D.
(Coroner.)

6-22 1922 (Address) 1106 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Patrick Cemetery	June 23 1922

20-UNDERTAKER,	ADDRESS
Elmer W. Cook	524 E Eager St.

state CAUSE OF DEATH in plain terms, so that it may be properly coded. Omission of certificate. is very important. See instructions on back of certificate.

D 65349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65349

CERTIFICATE OF DEATH.

REGISTERED No. C 139

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Sumrall

(Residence in Baltimore: No. 15-45-Lilmar St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 64 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

9-BIRTHPLACE. (State or Country). Balto. Md. U. S.

PARENTS.

10-NAME OF FATHER. W. Jamison

11-BIRTHPLACE OF FATHER (State or Country). —

12-MAIDEN NAME OF MOTHER Jane McElroy

13-BIRTHPLACE OF MOTHER (State or Country). Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M Elroy

(Address) 15-45-Lilmar

15-

Filed ....., 191.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk.

JUN 22 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Inter Nephritis

Uraemia

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

Chr Inter Nephritis (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner.)

June 22, 1922 (Address) 417 Cath

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cem	June 24, 1922
20-UNDERTAKER	ADDRESS
H. C. Branning Son	517 Schroeder

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65350

CERTIFICATE OF DEATH.

1 D 65350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1545 N. Gilmor ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Jamison

(a) RESIDENCE NO. 1545 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE OR CONDITION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Jamison

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Ellen

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mae M. Ellery

(Address) 1545 N Gilmor St

15 Filed ....., 19 .....

Registrar Robert P. Harrison,

Burial Permit Clerk

JUN 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to June 22, 1922,

that I last saw her alive on June 21, 1922,

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) 0 yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 1545 N Gilmor St

Did an operation precede death? no Date of — — —

Was there an autopsy? no

What test confirmed diagnosis? Widal, Diazo etc

(Signed) R B Kenyon, M. D.

, 19 (Address) 606 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: June 24 1922

20 UNDERTAKER: H. C. Brauning Son — ADDRESS: Edmondson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65351

CERTIFICATE OF DEATH.

45 D 65351

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Lamon ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Hardy

(a) RESIDENCE. NO. 1809 Lamon ST. 14 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 34 yr — Months — Days — If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Hamm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucy Gary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wilde

14 Informant (Address): Walter 1809 Lamon

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from about Dec. 15, 1922, to June 21, 1922, that I last saw h er alive on June 16, 1922, and that death occurred, on the date stated above, at 11:35a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma rectum

(duration) 0 yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary): exhaustion

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? microscopic

(Signed) Edward Swan, M. D.

. 19 (Address) 821 N. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: June 23 1922

20 UNDERTAKER: E. Pindell Inc — ADDRESS: 1463 Mon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

22 1922

Burial Permit Clerk.

Wm Sellman ✓

D 65352 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65352

CERTIFICATE OF DEATH. 4 X 165

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mrs Sellman

(Residence in Baltimore: No. West River Md St.; yrs. mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH. Dont Know (Month) (Day) 1..... (Year)

7-AGE. 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer). 186

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). Dont Know

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address)

15- Filed JUN 23 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ topsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid. Poisoning

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) yrs. mos. ds.

(Signed) W. R. Forrest M. D. (Coroner.)

6-22-1922 (Address) 117 N. Paca St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence West River Md.

19-PLACE OF BURIAL OR REMOVAL. Marlboro Md. DATE OF BURIAL. June 23 1922

20-UNDERTAKER. Henry H. Weitz & Co ADDRESS 1531 W. Lombard St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65353

D 65353

CERTIFICATE OF DEATH.

Registered No. C 170

1-PLACE OF DEATH

City of BALTIMORE: (No. 200 Linwood Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E Spitler

(Residence in Baltimore: No. 2805 Kate Avenue St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: May (Month) 14 (Day) 1878 (Year)

7-AGE: 44 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Accountant
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or Country): Virginia

PARENTS:

10-NAME OF FATHER: James M. Spitler

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Margaret Wisel

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Spitler

(Address) 2805 Kate Ave

15- Filed JUN 23 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 21 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Gun shot wound through heart (Suicide)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Thomassen M. D. (Coroner.)

192 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 23 1922

20-UNDERTAKER: William Cook — ADDRESS: 502 E North

state CAUSE OF DEATH in plain terms, so that it may be properly classified. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65354

161-001

D 65354

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home Infirmary 6

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nimmo

(a) RESIDENCE NO. Towson Md ST., ... WARD .....

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
born	—	—	=	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Church Home & Infirmary

PARENTS

10 NAME OF FATHER Mr. Sidney Nimmo

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Church Home & Infirmary (Address) Nurse Attendant

15 Filed JUN 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17 I HEREBY CERTIFY That I attended deceased from June 22, 1922, to June 22, 1922, that I last saw h[illegible] alive on June 22, 1922, and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Hepatic Toxaemia with Convulsions, Delivery by Caesarean Section

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature birth 5-6

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm D. Murray Jr. M. D.

June 22-22 19 (Address) 1107 St Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Hartford Co. Md. DATE OF BURIAL June 23 1922

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly Classified. Exact statement of DISEASE OR CONDITION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65355

CERTIFICATE OF DEATH.

D 65355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (Street) 19 31 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate G. Kummel

(a) RESIDENCE NO. 9 N. Mount St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? 40 yrs. 1 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. Kummel

6 DATE OF BIRTH (month, day, and year): May 3-82

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40 yrs	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ella

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Thos. Kummel 9 N. Mount St.

15 Filed JUN 23 1922 ROBERT R. KRAUTER, Registrar of Burial Permits.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-20 1922.

17 I HEREBY CERTIFY, That I attended deceased from 5-4- 1922, to 6-20 1922

that I last saw h[illegible] alive on 6-20 1922

and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/21/22

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) A. O. Harper, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 6/23/22

UNDERTAKER: Philip Herring — ADDRESS: 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65356

CERTIFICATE OF DEATH.

178 D 65356

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Patterson Park St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Hackett

(Residence in Baltimore: No. 3008 McCay St

St.; yrs., 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown, 1
(Month) (Day) (Year)

7-AGE 65 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Kane

(Address) 3720 Pratt St.

15-

FILED JUN 23 1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit ISSUED.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21st, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Unknown

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Thos. J. Hoffman M. D.
(Coroner)

June 22 191 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Accid

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, June 23, 1922

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65357

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 65357

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. 1431 Harford ave ST., 9 WARD)

2-FULL NAME Martha F Schroeder

(a) RESIDENCE NO. 1431 Harford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Henry L.H Schroeder

6 DATE OF BIRTH (month, day, and year) July 16th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Sweet air
(State or country) Balto Co

PARENTS
10 NAME OF FATHER John Fossett
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Rachael Lindeman
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Henry L. H Schroeder
(Address) 1431 Harford ave

15 Filed JUN 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1922, to June 22, 1922, that I last saw her alive on June 22, 1922, and that death occurred, on the date stated above, at 4.10 a. m.

The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? no Date of none
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) J. Lee Magness, M. D.
6 22, 1922 (Address) 120 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL June 24th 1922

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument st

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

D 65358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 65358

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 N. Calhoun St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Lowenstein

(Residence in Baltimore: No. 7 N. Calhoun St.; 60 yrs. ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH. March 7th, 1859 (Month) (Day) (Year)

7-AGE. 72 yrs. 3 mos. 13 ds.

If LESS than 1 day, ~ hrs. or ~ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): Butcher 013

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (State or Country). Not Known

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Lowenstein

(Address) 2 W. 15 Greenmount

15-

Filed JUN 23 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13th 1922, to June 20th 1922, that I saw him alive on June 20th 1922, and that death occurred, on the date stated above, at 9.57 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(Duration) ~ yrs. ~ mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 3 yrs. ~ mos. ~ ds.

(Signed) Joseph B. Sanner M. D.

June 21, 1922. (Address) 219 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ~ yrs. ~ mos. ~ ds. In the State ~ yrs. ~ mos. ~ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Oheb Shalom Cem. DATE OF BURIAL. 6/23, 1922

20-UNDERTAKER J. Ahrens Co ADDRESS 1611 Madison

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 65359

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 Hudson St. ST., 1 WARD)

2-FULL NAME Alice Bellman.

(a) RESIDENCE NO. 3011 Hudson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Bellman

6 DATE OF BIRTH (month, day, and year) Nov. 26 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Goodwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's Co. Md.

12 MAIDEN NAME OF MOTHER Millie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Frederick Bellman (Address) 3011 Hudson St.

15 Filed JUN 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to June 20, 1922, that I last saw h[illegible] alive on June 20, 1922, and that death occurred, on the date stated above, at 5 30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam.

(Signed) D. W Jones, M. D.

6/21/1922 (Address) 1011 N. Edwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 23 1922

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65360

D 65360

CERTIFICATE OF DEATH.

74-009

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2435 N. North Ave ST., 15 WARD)

2-FULL NAME Mrs Minnie Lange

(a) RESIDENCE NO. 2435 N. North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lange

6 DATE OF BIRTH (month, day, and year) 28 Nov 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abigail Spelshouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elsie Burkoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Lange (Address) 2435 N. North Ave

15 Filed JUN 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to June 21, 1922, that I last saw her alive on June 21, 1922, and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. 20 hours ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) O. N. Duvall, M. D.

, 19 (Address) 1817 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 24 1922

20 UNDERTAKER Josiah Lyter & Son — ADDRESS 1300 Harlem Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65361

CERTIFICATE OF DEATH.

74 B 65361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S Broadway ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Leimbach

(a) RESIDENCE NO. 28 S Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Leimbach

6 DATE OF BIRTH (month, day, and year) Feb 10 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath

PARENTS

10 NAME OF FATHER Robert White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Eva Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bath

14 Informant Herman Leimbach (Address) 126 S Broadway

15 Filed JUN 23 1922 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1922, to June 21, 1922

that I last saw her alive on June 21, 1922,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Paralysis + Telangiectasis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J Wade, M. D.

, 19 (Address) 115 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 24 19
20 UNDERTAKER	ADDRESS
Wendell Appel & Son	378 Lan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65362

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 D 65362

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Patterson Pk Ave ST., 6 WARD)

2-FULL NAME Ethel Fay Ribakow

(a) RESIDENCE No 103 N Patterson Pk Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William Ribakow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Rombro

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Balto

15 JUN 23 1922 ROBERT R. KRAUSE, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 23, 1922, that I last saw h[illegible] alive on June 22, 1922 and that death occurred, on the date stated above, at 3.12 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination Spinal Fluid

(Signed) Edgar F. Friedenwald, M. D.

June 23, 1922 (Address) 1616 London Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL June 23 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

IMPORTANT—Should be filled out in duplicate, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 65363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65363

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 625 N. Dallas St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Goldie Savoy Fisher

(Residence in Baltimore: No. 625 N. Dallas St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	

6-DATE OF BIRTH, May (Month) 14 (Day) 1921 (Year)

7-AGE, 1 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Kenneth Fisher

11-BIRTHPLACE OF FATHER, (State or Country), Anne Arundel Co

12-MAIDEN NAME OF MOTHER, Pocahontas Peyton

13-BIRTHPLACE OF MOTHER, (State or Country), Anne Arundel Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kenneth Fisher

(Address) 625 N. Dallas St

15-

Filed JUN 23 1922 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Fuller M. D. (Coroner.)

6-22-1922 (Address) 5 W. Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Marley Neck A. C. Co Md	6/24 1922
20-UNDERTAKER,	ADDRESS
Jas. Dr. Skinner	45 E. Read st

State CAUSE OF DEATH in plain terms. Item 16 is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65364

CERTIFICATE OF DEATH.

D 65364

1-PLACE OF DEATH Church Home & Hosp

CITY OF BALTIMORE: (No.) Broadway & Fairmount (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Kladner

(a) RESIDENCE No. 522 N. Lakewood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced — ~~HUSBAND of~~ ~~(or WIFE of)~~: Henry W. Dashner

6 DATE OF BIRTH (month, day, and year): May 1 — 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Peter Zinkand

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Henry W. Dashner 522 N. Lakewood ave

15 Filed JUN 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to June 22, 1922, that I last saw h alive on June 22, 1922, and that death occurred, on the date stated above, at 8.15 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis,
(Micrococcus Lanceolatus)

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Otitis media.
(duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Ray Hamilton Lauretson, M. D.

....., 19 (Address) Church Home & Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: June 24 1922

20 UNDERTAKER: Wm C. Miller — ADDRESS: 2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 blks.

Miller (~~Hefter~~)

D 65365 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65365

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 N Duncan ST.: 6 WARD)

2-FULL NAME Samuel D. Miller

(a) RESIDENCE. NO. 192 Duncan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Miller

6 DATE OF BIRTH (month, day, and year): Jan 27 1858

7 AGE: Years 64 — Months 4 — Days 24 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Painter

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Samuel Eschelbrger

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frederick Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mrs Rhum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Harry W. Sail

(Address) 92 Duncan St

15 Filed JUN 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to June 21, 1922, that I last saw h[illegible] alive on June 21, 1922, and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 7 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John J. Veth, M. D.

June 23, 1922 (Address) 936 S. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: June 24 1922

20 UNDERTAKER: Geo C. Miller

ADDRESS: 2334 Jefferson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65366 ✓ D 65366

D 65366 159-002

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1001 Hollins St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby McClain

(Residence in Baltimore: No. 1001 Hollins St. St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	single

6-DATE OF BIRTH, ... June 21, 1922 ..... (Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or 15 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Stocksdale

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Cathryn McClain

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cathryn McClain

(Address) 1001 Hollins St.

15- FILED JUN 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June 21, 1922 ..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquiry ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Cadeus foramen ovale .....

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... J. T. Hennessy, M. D. (Coroner.)

June 22, 1922 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER	ADDRESS
Commissioner Health, For Wm. E. Woodall	JUN 23 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.

1930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65367

CERTIFICATE OF DEATH.

188-001

Registered No. D 65367

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Hough & Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles Grayson

(Residence in Baltimore: No. 2037 Keyser st St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colrd

5-Single, Married, Widowed, or Divorced. (Write the word.) Marr'd

6-DATE OF BIRTH. Dont Know (Month) (Day) 1 (Year)

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, hrs. or uln.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. R.R. track worker
(b) General nature of industry, business, or establishment in which employed (or employer). R.R. 073

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Chas Grayson

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Paby Johnson

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) mrs R a. Elliott

(Address) 1725 Ashland ave

15- JUN 23 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull broken R. Arm Fractured Amputation R. foot + Crushed chest

(Duration) yrs. a few mins.

CONTRIBUTORY (Secondary) Shocked by R.R. train

(Duration) yrs. mos. ds.

(Signed) W K Sumwalt M. D. (Coroner.)

6/23 1922 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudel

DATE OF BURIAL. June 24th 1922

20-UNDERTAKER. mrs R a Elliott

ADDRESS 1725 Ashland

THE CAUSE OF DEATH must be stated plainly, so that it may be properly classified. Each certificate is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65368

CERTIFICATE OF DEATH.

57 D 65368

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 248 W. Woodland ave ST., 27 WARD)

2-FULL NAME Annie Eliz. Fleckenschilde

(a) RESIDENCE NO. 248 W Woodland ave ST., 27 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore A. Fleckenschilde

6 DATE OF BIRTH (month, day, and year) Jan 22nd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	61	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Atlanta Georgia

PARENTS

10 NAME OF FATHER George Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Colen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Theo A Fleckenschilde
(Address) 248 W Woodland Ave

15 Filed ....., 19..... Registrar

23 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to June 21, 1922

that I last saw h alive on June 21, 1922

and that death occurred, on the date stated above, at 2.55 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration 5 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D Rubert M. D.

, 19 (Address) 404 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	June 25 1922
20 UNDERTAKER	ADDRESS
Lilly & Gaither	403 N. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65369

CERTIFICATE OF DEATH.

90

D 65369

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 900 Ridgely ST.: 21 WARD)
REGISTERED NO. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Stiebel

(Residence in Baltimore: No. 900 Ridgely St.: 53 yrs. — mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 8th, 1869
(Month) (Day) (Year)

7-AGE, 53 yrs. — mos. 14 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Stiebel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Daubert

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Katie Ziegler
(Address) 625 N. Stricker St

15- Robert D. Harrison, Registrar.

N 23977

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22nd, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H K Gwynn M. D.
(Coroner.)

6-22, 191... (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery
DATE OF BURIAL, June 24 1922

20-UNDERTAKER Mrs. Mrs. John N. Teufel & Son
ADDRESS 801 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65370

CERTIFICATE OF DEATH.

100-091 D 65370

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marianna Kajawska

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed ..., 19... Registrar

23 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1922

17

I HEREBY CERTIFY, That I attended deceased from January 8, 1920, to June 22, 1922, that I last saw her alive on June 22, 1922, and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 10 yrs? mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

6/22/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	June 24 1922
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski	1000 S. Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of doctor is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65371

CERTIFICATE OF DEATH.

74-081 D 65371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 N. Mount ST.; 15 WARD)

2-FULL NAME Louise Geraldine Briscoe

(a) RESIDENCE. NO. 1405 Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. x mos. x ds. How long in U. S., if of foreign birth? x yrs. x mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph C. Briscoe

6 DATE OF BIRTH (month, day, and year) Dec 18-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired School teacher

(b) General nature of industry, business, or establishment in which employed (or employer) ~~~ 1168

(c) Name of employer Balto. Co. School Board

9 BIRTHPLACE (city or town) Wilmington
(State or country) North Carolina

PARENTS

10 NAME OF FATHER John D. Wilson

11 BIRTHPLACE OF FATHER (city or town) Wilmington
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ellen Louise Usher

13 BIRTHPLACE OF MOTHER (city or town) Wilmington
(State or country) North Carolina

14 Informant Elizabeth K. Smith
(Address) 2202 Druid Hill Ave

15 Filed ....., 19.... Registrar

123 1922 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922, to June 22, 1922, that I last saw h.. alive on June 22, 1922, and that death occurred, on the date stated above, at 2.22 p.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis & myocarditis

(duration) 2 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage 2 wks & nephritis (duration) ~ yrs. ~ mos. two ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) John E. St. Campen, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cmty	6-24 1922
20 UNDERTAKER	ADDRESS
George W. Holland	1651 Mount Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65372

D 65372

CERTIFICATE OF DEATH.

139

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Cherry St Curtis Bay WARD)

2-FULL NAME Peter Garreis

(a) RESIDENCE. No. 24 Cherry St ST., 25 WARD.
(Usual place of abode)
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Leona Garreis

6 DATE OF BIRTH (month, day, and year) June 29 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Leona Garreis wife
(Address) 24 Cherry St Curtis Bay

15 23 1922 . 19 Robert A. [illegible] Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11 . 19 22 . to June 21 . 19 22 .

that I last saw him alive on June 20 . 19 22 .

and that death occurred, on the date stated above, at 7 20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nefritis (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) .....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William Duffy . M. D.

. 19 (Address) 816 Bennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C A Co.	6-24 1922
20 UNDERTAKER	ADDRESS
E & B Stark	115 E West St

THIS IS very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65373

D 65373

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 4 X 111 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland V. Atkinson

(a) RESIDENCE. NO. Port Deposit Md ST., WARD Port Deposit Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan [redacted] Atkinson

6 DATE OF BIRTH (month, day, and year) July 3 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. A. Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Agnes Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hospital Records

15 Filed JUN 24 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1 1922, to June 23 1922

that I last saw h[redacted]m alive on June 23 1922

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer. General peritonitis

Fecal fistula (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Agnes D Norine, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Port Deposit Md	June 24 1922
20 UNDERTAKER	ADDRESS
H. Hall Courtson	2235 N Mott

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 65374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65374

CERTIFICATE OF DEATH.

REGISTERED NO. 15 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Riebling.

(a) RESIDENCE. NO. 3029 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Married~~. (Widow)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife. 00

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Geo. Dippel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Mrs. Lillian T. Zentz. 3029 W. North Ave.

15 Filed Robert P. Harrison, Registrar

JUN 24 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1922.

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 1922, to 6/23, 1922, that I last saw h-er alive on 6/23, 1922, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

~~Cardiac~~ Chronic interstitial nephritis, with uremia.

(duration) ✓ yrs. ✓ mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes. Date of 6/21/22.

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical exam.

(Signed) J. Willis Guyton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 26 1922
20 UNDERTAKER	ADDRESS
H. Mannel Ronten	2235 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65375

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1174 Washington Boulevard ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Marie Gauer

(a) RESIDENCE NO. 1174 Washington Boulevard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fitzhugh Lee Gauer

6 DATE OF BIRTH (month, day, and year) Oct. 13th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Ripley

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosa Brunn

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Fitzhugh Lee Gauer (Address) 1147 Washington Boulevard

15 Filed Robert [illegible], 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17

I HEREBY CERTIFY, That I attended deceased from March 15th, 1922, to June 24th, 1922, that I last saw her alive on June 24th, 1922, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs

(duration) — yrs. 7 mos. 4 ds.

18 Where was disease contracted if not at place of death? In home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Sullivan, M. D.

6/23, 1922 (Address) 1701A Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 26 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Disease or CONDITION is very important. See instructions on back of certificates.

N 24 1922 Burial Permit Clerk.

D 65376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65376

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Howard Shaffer

(Residence in Baltimore: No. 130 S. Monroe Street St.; 16 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

6-DATE OF BIRTH, November, 11th, 1876
(Month) (Day) (Year)

7-AGE, 45 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Steel Crane Operator
(b) General nature of industry, business, or establishment in which employed (or employer) Dietrich Bros

9-BIRTHPLACE, (State or Country) Baltimore Co., Md.

PARENTS.

10-NAME OF FATHER, Michael Shaffer

11-BIRTHPLACE OF FATHER, (State or Country), Balto. Co. Md.

12-MAIDEN NAME OF MOTHER, Miss Uppercue

13-BIRTHPLACE OF MOTHER, (State or Country), Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Nettie B. Shaffer
(Address) 130 S. Monroe STreet.

15-
Filed JN 24 1922 19?
Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June, 22 nd. 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Comp. fract leg.

Accidentally struck by car at Districts Run Curve

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
6. 23 1922 (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, June 26 1922

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Balto St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65377 X 34 D 65377

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Bailey

(a) RESIDENCE NO. Sherwood, Md. ST., ... WARD .....

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co., Md.

PARENTS

10 NAME OF FATHER Charles Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co. Md.

12 MAIDEN NAME OF MOTHER Katie Hasland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbott Co. Md.

14 Informant Hospital Records.

(Address) Municipal Hospital.

15 1922 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1922, to June 23, 1922, that I last saw h im alive on June 22, 1922, and that death occurred, on the date stated above, at 4 A.M.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of dorsal vertebrae

(duration) 1 yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) I. W. Brumbock, M. D.

6/23/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mickels — DATE OF BURIAL June 24 1922

20 UNDERTAKER John W Henderson — ADDRESS 1502 E monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Scilipoti

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 65378

D 65378

CERTIFICATE OF DEATH.

5 101

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 251 N. Exeter ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonino Scilipoti

(a) RESIDENCE. No. 251 N. Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosina Biscotti

6 DATE OF BIRTH (month, day, and year) Nov. 14 1887.

7 AGE 34 Years 7 Months 8 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Rosario Scilipoti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Filippa Scilipoti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosina Biscotti (Address) 251 N. Exeter St

15 Filed [illegible] 19 [illegible] Registrar

2 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to June 22, 1922, that I last saw him alive on June 22, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Cesagno, M. D.

June 24, 1922 (Address) Green Hills - Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemetery	6/24/1922
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65379

D 65379

CERTIFICATE OF DEATH.

REGISTERED NO. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N. Luzerne Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel S. Wilkinson

(a) RESIDENCE. NO. 138 N. Luzerne ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine Wilkinson

6 DATE OF BIRTH (month, day, and year) July 13/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER James Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Mary Galloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant (Address) Mrs. Catharine Wilkinson 138 N. Luzerne ave

15 Filed Sept 6 19 22 P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23/22

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 1921, to June 22 1922, that I last saw him alive on June 22 1922, and that death occurred, on the date stated above, at 1000 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Throat & Tongue.

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of Cautery

Was there an autopsy? no

What test confirmed diagnosis? Microscopic & Clinical

(Signed) F. C. Stoddard, M. D.

19 (Address) 143 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cem. June 26 1922

20 UNDERTAKER — ADDRESS

Jos. J. Kerr 156 N. Luzerne ave

CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2

1922

Vital Records Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65380

161 B 801
D 65380

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N. Glover ST. 19 WARD)

2-FULL NAME John P Myers

(a) RESIDENCE. NO. 418 N. Glover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 26/22

7 AGE — Years — Months: 5 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John P. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Emma F. Schaar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): John P Myers 418 N. Glover

15 Filed Robert P. Harrison, Registrar

6 24 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1922, to June 24, 1922, that I last saw him alive on June 23, 1922, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(duration) yrs. Life mos. ds.

CONTRIBUTORY (Secondary) Premature at 6 Months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Jones, M. D.

6.24.19 22 (Address) Dundalk

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem. DATE OF BURIAL: June 26 1922

20 UNDERTAKER: Jos. J. Herr ADDRESS: 156 N. Luzerne Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65381

D 65381

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Darley Ave ST.: 9 WARD)

2-FULL NAME. Wm L Jones

(a) RESIDENCE. No. 1232 Darley Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate E Jones

6 DATE OF BIRTH (month, day, and year) Dec 10 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Fred Zopp

(Address) 1232 Darley Ave

15 Filed 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to June 23, 1922

that I last saw him alive on June 22 1922

and that death occurred, on the date stated above, at ——— m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 14 mos. 23 ds.

CONTRIBUTORY (Secondary) Auto intoxication

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw G Coolahan M. D.

6/24/22 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	6/24 19
20 UNDERTAKER Geo W Farley Fulton & Forsythe	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

42

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65382

D 65382

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital. ST. ..... WARD)

2-FULL NAME Mr. William Jahelka

(a) RESIDENCE. No. 3710 North Road, Walbrook

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 6, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Wenclawa Jahelka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Klarova

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Otto Jahelka

(Address) 3710 North Road

15 Filed ..... 19..... Registrar

Robert F. Harrison,

Burial Permit Clerk

12 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is necessary. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to June 23, 1922, that I last saw him alive on June 23, 1922, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 12, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gordon S. Seagrave M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 27 1922

20 UNDERTAKER Morton Lakeyson ADDRESS 1874 W North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65383

129

D 65383

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 W. Lombard ST., 3 WARD)

2-FULL NAME Martha E. Williams

(a) RESIDENCE NO. 1317 W. Lombard ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Williams Nov-30-

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 61 Months 7 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): City.

PARENTS

10 NAME OF FATHER: Christ Heiner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant: Mrs Donahue

(Address) 1749 E Baltimore

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

6 24 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21/1922

17 I HEREBY CERTIFY, That I attended deceased from 6/11, 19 22, to 6/21, 19 22, that I last saw h alive on 6/20/22, 19 ....., and that death occurred, on the date stated above, at 5-45 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac infarction

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephr.

(duration) 1 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. Vinson M. D.

6/24, 19 22 (Address) 1302 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: 6/24 19 22

ADDRESS 2000 E Baltimore

20 UNDERTAKER: J A Moran

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65384

CERTIFICATE OF DEATH.

74-001

D 65384

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Robinson ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Call

(a) RESIDENCE. NO. 319 S. Robinson ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

2

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Bernard Call

6 DATE OF BIRTH (month, day, and year) Jan 25 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Birene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Call

(Address) 319 S. Robinson

15 Filed 1922 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to June 22, 1922

that I last saw her alive on June 22, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B Tillow M. D.

6/22 1922 Address 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemy	6/26/1922

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65385

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 40 E Mulgmury ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Roberts

(a) RESIDENCE NO. 40 E. Mulgmury ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Elmira N Roberts

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer) B C & A Pier #4.

(c) Name of employer B. C & A. Co.

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Va

PARENTS

10 NAME OF FATHER Clay Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Raymond E Roberts
(Address) 94 Mosher St

15 Filed 1922 Robert P. Harris.., Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8th, 1922, to June 22nd, 1922, that I last saw him alive on June 22nd, 1922, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) C D Buxton, M. D.

6/23/1922 (Address) 301 E Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	June 26 1922
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65386

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 13 N Luzerne Ave. WARD 6)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Bohm Sr

(a) RESIDENCE NO. 13 N Luzerne Ave WARD 6
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmine Bohm

6 DATE OF BIRTH (month, day, and year) Jan 22 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retire Grocery

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Bohm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Fred Bohm Jr (Address) 13 N Luzerne Ave

15 Filed 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1922, to June 23, 1922, that I last saw h[illegible] alive on 6 23, 1922, and that death occurred, on the date stated above, at 4 20 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

Decline

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) C. G Heuer, M. D.

6/23 1922 (Address) 2600 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuels Cemetery	June 26 1922
20 UNDERTAKER	ADDRESS
Louis Heemann	326 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 2

Spec.—1-10-21—M&T—1500 Bks.

D 65387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65387

131

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Muntcipal Hospital ST., 7 WARD)

2-FULL NAME Aaron Phillips

(a) RESIDENCE NO. 913 Shelter St. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norfolk, Va.

PARENTS

10 NAME OF FATHER Phillip Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed JUN 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922 to June 22, 1922, that I last saw h im alive on June 22, 1922, and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

[redacted] polyaptic Kidneys

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Morrill M. D.

6/23/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL 24 June 1922

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1725 Oakland A.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16558 D 65338

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 65388

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Williams

(a) RESIDENCE NO. 518 N. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	148	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Click Pullitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Mary Jane Pullitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt—

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 JUN 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922, to June 22, 1922, that I last saw her alive on June 22, 1922, and that death occurred, on the date stated above, at 10:25 P m.

The CAUSE OF DEATH* was as follows:

Myocardial malfunction

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. Sidney Burwell, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL June 26 1922

20 UNDERTAKER Mrs R A Elliott ADDRESS 1725 Ashland Av

mation should be careful, supplies. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65389

CERTIFICATE OF DEATH.

38 D 65389

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ellsworth

(a) RESIDENCE NO. 204 S. Spring St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE — Years: 57 — Months: -- — Days: -- — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records, Municipal Hospital. (Address)

15 Filed JUN 22 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 16, 19 22, to June 22, 19 22, that I last saw him alive on June 21, 19 22, and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortic Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

6/23/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: JUN 23 1922 19

20 UNDERTAKER: [illegible] Health.

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65390

CERTIFICATE OF DEATH.

31 D 65390

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD 2)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edham Ibrahim

(a) RESIDENCE. NO. Sailors' Home S. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tripoli

PARENTS

10 NAME OF FATHER Hasen Ibrahim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tripoli

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tripoli

14 Informant Hospital Records

(Address) M.T.H.

15 Filed ..... 19 ..... Registrar .....

JUN 2 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1922, to June 21, 1922, that I last saw him alive on June 21, 1922, and that death occurred, on the date stated above, at 5.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and enteritis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dadaglacca M. D.

6-21-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL JUN 2 1922

20 UNDERTAKER Commissioner Health,

ADDRESS

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE OR CONDITION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65391

D 65391

CERTIFICATE OF DEATH.

5 - 112

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Asquith ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Thompson

(Residence in Baltimore: No. 207 Asquith St.; 70 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Unknown (Month), (Day), 1847 (Year)

7-AGE. 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Lexington Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anderson

(Address) 325 W. Biddle St.

15-

Robert P. Harrison,

Filed ....., 191.....

JUN 23 1922 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21 1922, to June 22 1922, that I saw h.. alive on June 22 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Stomach
Cardiac Muscular Asthenia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Young M. D.

6/26, 1922 (Address) 1729 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. June 24 1922

20-UNDERTAKER Samuel Hemsley

ADDRESS 378 N Biddle

CAUSE OF DEATH to be plain terms so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65392

CERTIFICATE OF DEATH.

1803
18 D 65392

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. M. Wilson

(Residence in Baltimore: No. 715 N. Lafayette Ave St.; yrs., 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Negro

5-(Single, Married, Widow(er) or Divorced, (Write the word.) Widower

6-DATE OF BIRTH, March 24 (Month) (Day) 1867 (Year)

7-AGE, 55 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) Caterer

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Wilson (Son)

(Address) 1516 McCulloh St

15-

Filed ..... 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21 (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Shock by automobile accident
McMechen St & Pennsylvania Ave

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. ....mos. ....ds.

(Signed) J. S. T. Owen M. D. (Coroner.)

6-22 192.2 (Address) 508 E. York Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, June 25 19 22

20-UNDERTAKER, J. Emmett A. Adams — ADDRESS 1300 Eutaw Place

state CAUSE OF DEATH in plain terms, so that it may be properly classified. The information is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65393 38 D 65393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Waverly Johnson

(a) RESIDENCE NO. 141 Colvin St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore 074

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Cornelius Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Lucy Janet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records.
(Address) Municipal Hospital.

15 Filed ..... 19 .....
6 24 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to June 23, 1922, that I last saw him alive on June 22, 1922, and that death occurred, on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortic insufficiency (duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Clyde McNeil, M. D.

6/23/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: June 26 1922

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

D 65394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65394

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Mercy Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Monza Parks

(a) RESIDENCE No. 933 E Lanvale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Parks.

6 DATE OF BIRTH (month, day, and year) May 15-1855

7 AGE Years 66 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O F D

(c) Name of employer Maryland

9 BIRTHPLACE (city or town) (State or country) Back River Md.

PARENTS

10 NAME OF FATHER Monza Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Back River Md

12 MAIDEN NAME OF MOTHER Anna League

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Back River Md

14 Informant Mary C Parks (Address) 933 E Lanvale St. City

15 Filed JUN 24 1922 Robert P. Harrison, Registrar

16 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1922 to June 23, 1922

that I last saw him alive on June 23, 1922

and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

Metastasis of Glands of Groin

(duration) 3 mos yrs. mos ds.

CONTRIBUTORY (Secondary) Cachexia Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 5-25-22

Was there an autopsy? No.

What test confirmed diagnosis? Yes Lab

(Signed) David J Nusbaum M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL June 24 22

20 UNDERTAKER Wm Cork

ADDRESS N 5 Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

155682 D 65395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Angil

(a) RESIDENCE NO. 1258 Beechwood Rd ST. Towson WARD Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) May 5-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Angil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Roumania

12 MAIDEN NAME OF MOTHER Mary Kenney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to June 23 1922, that I last saw him alive on June 23, 1922, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Syphilis - Congenital.

(duration) yrs. 1 mos. 18 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Wa R. —

(Signed) Clendenning, M. D.

6/26, 1922 (Address) J H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Road — DATE OF BURIAL June 24 1922

20 UNDERTAKER Wm Cook — ADDRESS Y & G Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DIAGNOSIS is very important. See instructions on back of certificates.

24 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65396

CERTIFICATE OF DEATH.

179 D 65396

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Volunteers of America Hospital 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Boyd.

(a) RESIDENCE. No. 1014 W. Fayette ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Wm. J. Boyd

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William J. Boyd (Address) 1014 W. Fayette St

15 Filed JUN 25 1922 19.. ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to June 24, 1922, that I last saw her alive on June 23, 1922, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Albumen Test

(Signed) Albert F. Conway, M. D.

, 19 (Address) Volunteers of America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jun 26 1922
20 UNDERTAKER George J Smith	ADDRESS 1000 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

✓65397

(53189 D 65397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 65397

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4 WARD)

2-FULL NAME Ella Ward

(a) RESIDENCE NO. 216 Eutaw St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) July 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Bowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1922, to June 23, 1922

that I last saw her alive on June 23, 1922,

and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? No Date of

Was there an autopsy? Yes. What test confirmed diagnosis? Tuberculin reaction & X rays.

(Signed) Horace G. Stewart, M. D.

6/23, 19 22 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 6/24 1922

20 UNDERTAKER Robert F Mullins

ADDRESS 1106 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

√65398

D 65398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 65398

REGISTERED NO. C.....

1-PLACE OF DEATH St Frances Convent

CITY OF BALTIMORE: (No. Forest & Chase St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Johnson

(Residence in Baltimore: No. Forrest & Chase St. St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, Col.

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Dec. (Month) 3 (Day) 1893 (Year)

7-AGE, 28 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), New York City

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother M. Thaddeus

(Address) St Frances Convent E Chase West Forrest St.

15- Filed JUN 25 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1921, to June 23 1922, that I saw her alive on June 23 1922, and that death occurred, on the date stated above, at 1030 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mary F. Voeglein M. D.

June 23, 1922 (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, June 28, 1922

20-UNDERTAKER Geln B Pye ADDRESS 1022 Gilmor St

CAUSE OF DEATH: The primary cause of death is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

66399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65399

CERTIFICATE OF DEATH.

H 9 D 65399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 President ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Morisi

(a) RESIDENCE NO. 318 President ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Keeper 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Morisi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Guarilla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Emile Morisi

(Address) 318 President St

15 JUN 25 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1922

17

I HEREBY CERTIFY, That I attended deceased from June, 1921, to June 23d, 1922, that I last saw him alive on June 18th, 1922, and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the lung

about 1 yrs. mos ds. (duration)

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & x ray

(Signed) A F Rei, M. D.

June 24, 1922 (Address) 20 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL H Vincent — DATE OF BURIAL June 26 1922

20 UNDERTAKER Windell Duffy & Son — ADDRESS 878 N

65400 HEALTH DEPARTMENT—CITY OF BALTIMORE 65400

D 65400 CERTIFICATE OF DEATH. 114 D 65400

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1505 Nelson St ST.: 3 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wladyslaus Bielski

(Residence in Baltimore: No. 1505 Nelson St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mal	W	Single

6-DATE OF BIRTH, Apr (Month) 6 (Day), 1920 (Year)

7-AGE, 2 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed (or employer) ---

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jan Bielski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Agatha Bajorek

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jan Bielski

(Address) 1505 Nelson St

15- JUN 25 1922 Filed ..... 191.... ROBERT R. KRAUTER, Burial Permit Clerk ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 23 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ... yrs. 7 hrs ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos R. Horton M. D.

(Coroner)

June 24 1922 (Address) Curtis Bay Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Mal

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, June 24, 1922

20-UNDERTAKER John H Weber ADDRESS 1803 Bank

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65401

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Foot of Henry St. St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles E. Reason. (C)

(Residence in Baltimore: No. 525 N. Fremont Ave. St.; 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. November 30th. 1883. 1.....
(Month) (Day) (Year)

7-AGE. 38 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore. D14
(b) General nature of industry, business, or establishment in which employed (or employer). Clyde S/S Co.

9-BIRTHPLACE. (State or Country). Kent Co. Md.

PARENTS.

10-NAME OF FATHER. Joseph Reason. (C)

11-BIRTHPLACE OF FATHER. (State or Country). Kent Co. Md.

12-MAIDEN NAME OF MOTHER. Annie Comegy. (C)

13-BIRTHPLACE OF MOTHER. (State or Country). Kent Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ollay A. Reason, (C) wife.

(Address) 525 N. Fremont Ave.

15- JUN 25 1922 Filed ..... 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Missing June 20. 1922.
Body found June 22nd. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Bernardt M. D.
(Coroner.)

June 23 192 2. (Address) 10.17 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Calvary Cem	June 28th 22
20-UNDERTAKER. David Easton	ADDRESS 916 Saratoga

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Cases attended by coroner require certificate of certificate. See instructions on back of is very important.

D 65402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 65402

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1146 Cooksie Street St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Frances Jakubowski.

(Residence in Baltimore: No. 1146 Cooksie Street. St.; 2 yrs., 10 mos., 1. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White.	Single.

6-DATE OF BIRTH, August 23rd, 1919.
(Month) (Day) (Year)

7-AGE, 2 yrs. 10 mos. 1. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Boleslaw Jakubowski.

11-BIRTHPLACE OF FATHER, (State or Country). Poland.

12-MAIDEN NAME OF MOTHER, Alexandria Glatkowsky

13-BIRTHPLACE OF MOTHER, (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexandria Jakubowski. Mother

(Address) 1146 Cooksie Street.

15- Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24th. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Jun 25, 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary.	6/26 1922
UNDERTAKER.	ADDRESS
Wm Fiallowski	1618 Eoake

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Item 17 is very important. See instructions on back of certificate.

Spec.--1-10-21--M&T--1500 Bks.

D 65403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 65403

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 901 S. Sixth ST. 7th WARD)

2-FULL NAME Louis W. Swingler Jr.

(a) RESIDENCE NO. 901 S. Sixth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Swingler

6 DATE OF BIRTH (month, day, and year) Oct. 8-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	23	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis W. Swingler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Katharine Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Margaret Swingler

(Address) 901 S. Sixth St

15 FILED JUN 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY That I attended deceased from Jan. 1, 1922, to June 23, 1922,

that I last saw h~~is~~ alive on June 23, 1922,

and that death occurred, on the date stated above, at 8½ P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Diffused both Lungs

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas N. Magruder M. D.

, 19 (Address) 14. East Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland

DATE OF BURIAL June 26 1922

20 UNDERTAKER Finkler & Finkler

ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-001

REGISTERED NO. D 65404

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 N. Bond ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Davidson

(a) RESIDENCE. No. 1417 N. Bond St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Richard Davidson

6 DATE OF BIRTH (month, day, and year) Sept 17, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Thomas Dobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hepzibah Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mrs. Adela Hopf 1417 N. Bond St.

15 Filed JUN 25 1922, 19 ROBERT R. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1921, to June 24, 1922, that I last saw her alive on June 24, 1922, and that death occurred, on the date stated above, at 11.55 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Left hemiplegia)

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Amer Bowden, M. D.

6/24, 1922 (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: June 27 1922

20 UNDERTAKER: Zirkeler & Zirkeler ADDRESS 1734 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65405

CERTIFICATE OF DEATH.

113 D 65405

1-PLACE OF DEATH Garrett Hospital for Children REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Otter

(a) RESIDENCE NO. 1826 N. Port ST. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30-192

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3 moo		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Otter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Carrie Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant William Otter (Address) 1826 N Port St

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to June 23, 1922, that I last saw him alive on June 23, 1922, and that death occurred, on the date stated above, at 10.50 P m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Intestinal Indigestion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Charles L. Warner, M. D.

, 19 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 6/26 1922

20 UNDERTAKER William Cook — ADDRESS 502 N Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65406

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2814 E. Monument St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Klenia Jr

(a) RESIDENCE. No. 2814 E. Monument St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 24/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Richard H Klenia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Klenia Austria

12 MAIDEN NAME OF MOTHER Signa Erhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs A. Klenia

(Address) 2814 E Monument St.

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1922, to June 24, 1922, that I last saw h[illegible] alive on June 20, 1922, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

CONTRIBUTORY (Secondary) Ephaustran (duration) 2 yrs. mos. 8 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. H. Campbell, M. D.

6-24-1922 (Address) 1644 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A&Co	6/26/22
20 UNDERTAKER	ADDRESS
William Cook	502 E Nor[illegible]

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 65407

REGISTERED NO. D 65407

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1415 N. Bentalow ST., (Ward)

2-FULL NAME Rachel E. Gonder

(a) RESIDENCE (Usual place of abode) No. 1415 N. Bentalow ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Gonder

6 DATE OF BIRTH (month, day, and year): July 1-1839

7 AGE: Years 84; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Alonzo Houck (Address) Alexandria Va

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 16th, 1922, to June 24th, 1922, that I last saw h[illegible] alive on June 24th, 1922, and that death occurred, on the date stated above, at 6.44 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Hardening of Arteries (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Symptoms

What test confirmed diagnosis?

(Signed) [illegible] M.D.

. 19 (Address) 607 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 6/26 1922

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Nova

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65408

CERTIFICATE OF DEATH.

113 D 65408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Barclay St ST., 12 WARD)

2-FULL NAME Doris May LeGrow

(a) RESIDENCE NO. 1723 Barclay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Chas Galloway

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margt Timms

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Russel Seguin
(Address) 1723 Barclay St

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24th, 1922, to June 24, 1922, that I last saw h alive on June 24, 1922, and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Dearrhoea & Enteritis.
This child had been complaining two days before I was called in

(duration) 1 yrs. 7 mos 1 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J K Galloway, M. D.

, 19 (Address) 318 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Hampden — DATE OF BURIAL June 26 1922

20 UNDERTAKER Wm Cook — ADDRESS Mt St Mt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 65409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65409

CERTIFICATE OF DEATH.

REGISTERED NO. 24 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 E. Randall St. ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Hall

(a) RESIDENCE. NO. 128 E. Randall St. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice V. Hall

6 DATE OF BIRTH (month, day, and year) Oct. 10 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER John Hall

11 BIRTHPLACE OF FATHER (city or town) Norfolk Va.
(State or country)

12 MAIDEN NAME OF MOTHER Serah Ashbury

13 BIRTHPLACE OF MOTHER (city or town) Norfolk Va.
(State or country)

14 Informant Mrs. John T. Hall
(Address) 128 E. Randall St.

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to June 23, 1922
that I last saw h live on June 22, 1922
and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary) Obstruction (duration) yrs. 3 mos. ... ds.

(duration) yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell, M. D.

June 24 1922 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Cemetery	6. 26 19
20 UNDERTAKER J. Fenw McCully	ADDRESS 130 E. Fort.

CAUSE OF DEATH in plain terms, so that it may be properly CODED. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65410

CERTIFICATE OF DEATH.

113 D 65410

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3130 Elliott St.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Schultz

(a) RESIDENCE. No. 3130 Elliott St., 1st WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov. 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	—	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) infant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph F. Schultz

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ann M. Koridinska

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Joseph F. Schultz
(Address) 3130 Elliott St.

15 Filed JUN 25 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 22

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to June 24, 1922, that I last saw him alive on June 24, 1922, and that death occurred, on the date stated above, at 7:50 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia following acute gastro enteritis

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) Bottle fed

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. A. Naught, M. D.

June 24, 1922 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 26 1922
20 UNDERTAKER Stephen J. Fralkowski	ADDRESS 1000 S. Kenwood

mation should be carefully supplied. Also always CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65411 D 65411

CERTIFICATE OF DEATH.

74-001 REGISTERED NO.

1-PLACE OF DEATH Baltimore and Payson

CITY OF BALTIMORE: (No. German Aged Home ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Hanne.

(a) RESIDENCE. NO. German Aged Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER George Lederer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Friedricke Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Records. German Aged Home
(Address) Baltimore & Payson Sts.

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 21st, 1922, to June 24th, 1922, that I last saw her alive on June 23rd, 1922, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John Haupt, M. D.

19 (Address) 1043 W Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	June 26 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 65412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65412

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2809 Ulman Avenue ST. 15 WARD)

2-FULL NAME Sarah L. Hooker

(a) RESIDENCE No. 2809 Ulman Avenue ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: C. Frank Hooker

6 DATE OF BIRTH (month, day, and year): Jany 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co, Md

PARENTS

10 NAME OF FATHER: Jos. Edwards Delafslaine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fred. Co, Md

12 MAIDEN NAME OF MOTHER: Cath. Hitesheu

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Md

14 Informant: Clarence E. Hooker
(Address) 2809 Ulmain Ave

15 JUN 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23rd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 18th. 1922, to June 22nd. 1922, that I last saw her alive on June 22nd. 1922 and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Endocarditis with failing compensation.

(duration) one yrs. -- mos -- ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) — yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Dworaer, M. D.

6/23, 1922 (Address) #1817 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: June 26 1922

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 Mulberry St.

mation should be carefully supplied. Also answer all questions. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65413

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

179 D 65413

REGISTERED No. C

CITY OF BALTIMORE (No. Mercy Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Peppler

(Residence in Baltimore: No. 1834 N. Collington Ave St.; yrs., 49 mos. 9 ds. 7)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Sept. 16, 1872
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
49 yrs. 9 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sheet Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer): O&F

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Peppler

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Barbara Acker

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Peppler

(Address) 1834 N Collington

15- JUN 25 1922 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

May have had pulmonary or cardiac Disease or both

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration).....yrs.....mos.....ds.

(Signed) H. G. Fahy M. D.
(Coroner)

June 24, 1922 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Dulaney Cemetery	June 25, 1922

20-UNDERTAKER George A. Fahy ADDRESS Fulton & Fayette

N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65414 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 65414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 523 Ridge Ave. (ST.) Raspeburg (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Florence Potts

(a) RESIDENCE NO. 523 Ridge ave. ST. Raspeburg WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph H. Potts

6 DATE OF BIRTH (month, day, and year): Sept. 28 1850

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Jacob Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio Ohio

12 MAIDEN NAME OF MOTHER: Hannah McKinley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio Ohio

14 Informant: Arthur Rossiter (Address) 523 Ridge ave. Raspeburg

15 Filed JUN 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 24, 1922, that I last saw h[illegible] alive on June 24 1922, and that death occurred, on the date stated above, at 7 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 hr ds.

CONTRIBUTORY (Secondary): Arteriosclerosis (duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Leonard E Leach M. D.

, 19 (Address) 1431 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Philadelphia Pa. DATE OF BURIAL: June 26, 22

20 UNDERTAKER: Fred L Leach & Sons ADDRESS: Fullerton Md.

mation should be carefully supplied. AGE should be stated in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65415

HEALTH DEPARTMENT—CITY OF Marley BALTIMORE

CERTIFICATE OF DEATH.

177 D 65415

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Marley

(Residence in Baltimore: No. 1125 - Hanover St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov. (Month) 28 (Day), 1857 (Year)

7-AGE, 64 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jos Marley

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Hartley

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Marley

(Address) 1125 Hanover

15 Filed JUN 25 1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Setting fire to clothing while demented.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. Finley M. D.

June 23, 1922 (Coroner) (Address) 763 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	June 26, 1922
20-UNDERTAKER Margaret A. Fagan	ADDRESS 1427 Light St

N.B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 65416 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 65416

15-C 65416 CERTIFICATE OF DEATH. 32 D 65416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celma Jeffrey

(a) RESIDENCE NO. 2803 Bernard St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Chas. Jeffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C.

12 MAIDEN NAME OF MOTHER Rosie Jeffrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 ROBERT R. KRAUTER, 19 Burial Permit Clerk. Registrar

N 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1922

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1922, to June 25, 1922, that I last saw her alive on June 25, 1922, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H H Meech, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	June 26 1922

20 UNDERTAKER	ADDRESS
J. Pa Cu Davis	3307 Raine

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65417 HEALTH DEPARTMENT—CITY OF BALTIMORE. ✓ 65417

D 65417 CERTIFICATE OF DEATH. 38 D 65417

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mt Sinai Hospl ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winnifred E. Bump

(a) RESIDENCE. NO. 106 Dorsey Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert E Bump

6 DATE OF BIRTH (month, day, and year) 8/3/1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston, Mass.

PARENTS

10 NAME OF FATHER Jno Murria

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Bertha Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Robert E Bump (Address) 106 Dorsey st

15 FILED JUN 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23/22

17 I HEREBY CERTIFY, That I attended deceased from 6/12/22, 19.., to 6/23/22, 19.., that I last saw h[illegible] alive on 6/23/22, 19.., and that death occurred, on the date stated above, at 8.05 p. m.

The CAUSE OF DEATH* was as follows: Cardiac Sprue Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clin. Sympts

(Signed) J A Tomaszewicz, M. D.

, 19.. (Address) Mt Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 26 1922
20 UNDERTAKER	ADDRESS
Josiah Syler	1600 N Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 26 1922

Spec.—1-10-21—M&T—1500 Blks.

D 65418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65418

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pruchewski

(a) RESIDENCE NO. 821 S. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Pruchewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Novak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records,

(Address) Municipal Hospital.

15 Filed JUN 26 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1922, to June 23, 1922,

that I last saw him alive on June 22, 1922,

and that death occurred, on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma of tongue

(duration) yrs. 6? mos. ds.

CONTRIBUTORY (Secondary) Metastasis to neck

(duration) yrs. 3? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Zinnbeck, M. D.

6/23/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL June 26 1922

20 UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

Burial Permit Clerk

mation should be carefully supplied. Note should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificates.

D 65419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65419

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1705 Etting St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Martha A. Sheridan

(Residence in Baltimore: No. 1705 Etting St.; yrs. 83 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

6-DATE OF BIRTH, about (Month) (Day) 1839 (Year)

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fleming Sheridan

(Address) 1705 Etting St.

15-

JUN 9 1922

ROBERT F. KNAUER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 24 1922 (Address) 200 Cathedral

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. 1 mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cem. DATE OF BURIAL, June 26 1922

20-UNDERTAKER, Samuel Wesley Riddle ADDRESS 578

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 65420

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Penn ST.: 4 WARD)

2-FULL NAME Thelma Lannie Washington

(a) RESIDENCE. No. 15 Penn ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 27 / 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Emma Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hattie Washington Foster mother (Address) 15 Penn St

15 Filed JUN 26 1922 . 19 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, that I attended deceased from Feb 14 —, 1922, to June —, 1923, that I last saw h[illegible] alive on June 22, 1922, and that death occurred, on the date stated above, at 11 a — m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pleurisy and Lungs —

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) Samuel A Bain, M. D.

, 19 (Address) 137 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 27 22

20 UNDERTAKER Samuel Wensley ADDRESS [illegible] Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65421 HEALTH DEPARTMENT—CITY OF BALTIMORE 1922 D 65421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Pier #2 Locust Point. St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Willian L. Parker. (C).....

(Residence in Baltimore: No. 1617 W. Lexington St. St.; 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. December 18th. 1895. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
26 yrs. 6 mos. 5 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stevedore.
(b) General natnre of Industry, business, or establishment in which employed (or employer)..... M & M Transp co.

9-BIRTHPLACE, (State or Country). Atlanta Ga.

PARENTS.

10-NAME OF FATHER, William L. Parker. (C)

11-BIRTHPLACE OF FATHER, (State or Country). Atlanta Ga.

12-MAIDEN NAME OF MOTHER. Chency Jenkins. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Atlanta Ga.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen N. Parker. (C) wife.

(Address) 1617 W. Lexington St.

15- Filed JUN 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23rd. 1922, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to n/a death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a boat.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Wm. A. Leonard M. D.
(Coroner.)

June 25 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem. DATE OF BURIAL, June 26 1922

20-UNDERTAKER, Samuel Kennedy ADDRESS 578 N. Bridge St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

over

D 65422

CERTIFICATE OF DEATH.

24 79 D 65422

1-PLACE OF DEATH U. S. V. Hospital #56 Registered No. C.....

City of BALTIMORE: (No. Fort McHenry. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George P. Mitsos.

(Residence in Baltimore: No. 123 W. 101st. St. New York, N. Y. St.; yrs. En route. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
31 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION: 036
(a) Trade, profession, or particular kind of work: 2nd. Assist Engineer,
(b) General nature of industry, business, or establishment in which employed (or employer): S/S De Soto.

9-BIRTHPLACE, (State or Country). Chicago, Ill. (Greece)

PARENTS.

10-NAME OF FATHER. James P. Mitsos (Do not know)

11-BIRTHPLACE OF FATHER. (State or Country). Greece (Do not know)

12-MAIDEN NAME OF MOTHER. Sophie Michael (Do not know.)

13-BIRTHPLACE OF MOTHER. (State or Country). Greece (Do not know.)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Kenzie. O. D.

(Address) Fort McHenry.

15- ROBERT N. KRAUTER. Registrar.

Filed JUN 26 1922 192 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 24th. 1922. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Scalded about the body by escaping steam from a boiler of S/S De Soto.
Accidental Death.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Fernandez M. D. (Coroner.)

June 25. 1922 (Address) 917 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Accident at Solomons Island Md.

Former or usual residence June 23rd. 1922.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New York	June 26, 1922
20-UNDERTAKER.	ADDRESS
Fudeler & Pirkler	1739 Eager St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65423

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 Cedarcroft Road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Weed

(a) RESIDENCE. NO. 408 Cedarcroft Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabell Hall

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 186

(b) General nature of industry, business, or establishment in which employed (or employer) Sash and Door

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jonathon Weed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Hannah Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant William B. Weed Jr
(Address) 408 Cedarcroft Road

15 Filed JUN 26 1922, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1920, to June 24, 1922, that I last saw h.. alive on June 24, 1922, and that death occurred, on the date stated above, at 5. a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Enlarged Prostate & Operation for Same (duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 1922

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Leo N. Hrabing, M. D.

, 19 (Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	6/26, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

D 65424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65424

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 Preston St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Hosea G. White

(Residence in Baltimore: No. 503 Preston St. St.; 9 yrs. 11 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. July 2 1912
(Month) (Day) (Year)

7-AGE. 9 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Student
(b) General nature of Industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Chas. A. White

11-BIRTHPLACE OF FATHER, (State or Country). Penna

12-MAIDEN NAME OF MOTHER. Charlotte Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. A. White

(Address) 503 Preston St.

15-

Filed JUN 26 1922 19.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 23 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. T. Hennessy M. D.
(Coroner.)

June 23 1922 (Address) 250 Cathedral

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn DATE OF BURIAL. June 26 1922

20-UNDERTAKER. John H. Toadvine ADDRESS 143 Uniform St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65425

CERTIFICATE OF DEATH.

109-002

D 65425

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 S. Bethel ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion E. Griffin

(a) RESIDENCE. NO. 246 S. Bethel ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Isiah Griffin

6 DATE OF BIRTH (month, day, and year) April 27, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER Thomas H. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Margarite Shuer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Troy N.Y.

14 Informant Beatrice Burley (daughter) (Address) 246 S. Bethel St

15 Filed JUN 26 1922, 19.. Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922 to June 24, 1922, that I last saw h.. alive on June 23, 1922, and that death occurred, on the date stated above, at 8.40 A. m.

The CAUSE OF DEATH* was as follows:

Peri-Tonsilar Abscess
& Marked Gingivitis
& and Antrum infection.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Toxemia.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. L. Stuart, M. D.

, 19 (Address) 429 E. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — DATE OF BURIAL June 25 1922

20 UNDERTAKER Theo White. — ADDRESS 123 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65426

CERTIFICATE OF DEATH.

K 47

D 65426

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16 St. WARD)

2-FULL NAME Mrs. Mary E Gordon

(a) RESIDENCE NO. Pittsburgh. Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H. Gordon

6 DATE OF BIRTH (month, day, and year) June 11th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harpers Ferry W. Va.
(State or country)

PARENTS

10 NAME OF FATHER John A. Cruzen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harpers Ferry W. Va

12 MAIDEN NAME OF MOTHER Emma M. Wagner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Cumberland Md

14 Informant E. E. Cruzen
(Address) 504 Poplar Ave Baltimore Md

15 JUN 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) June (day and year) 25 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 31 19 22 to June 25 19 22

that I last saw her alive on June 25 19 22,

and that death occurred, on the date stated above, at 10:05 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? yes Date of June 22, 22

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Cayetano Paunetto, M. D.

19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md

DATE OF BURIAL 6-26 1922

20 UNDERTAKER Henry W. Jenkins & Son Co

ADDRESS Richard Ine Cullohe

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65427

CERTIFICATE OF DEATH.

1/01 D 65427

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Hart

(a) RESIDENCE. NO. 607 N. Gay St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 5 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Hart

6 DATE OF BIRTH (month, day, and year) Jan 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Ind

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dillie Rick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Baltimore St.

15 Filed JUN 26 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25/22 19

17 I HEREBY CERTIFY, That I attended deceased from 5/6/22, 19, to 6/25/22, 19,

that I last saw h/is alive on 6/25/22, 19,

and that death occurred, on the date stated above, at 6.10 A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ZZ Zinberg, M. D.

6/25, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Friendship	6-26 1922
20 UNDERTAKER	ADDRESS
Jack Lewis,	1439 E. Balto.

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 65428

HEALTH DEPARTMENT—CITY OF BALTIMORE

1915 D 65428

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Nursery Bldg ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Harry Lamberti

(Residence in Baltimore: No. 1408 Gay St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Wid

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): City

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Gunther

(Address) 1 Rogers Ave near Pentz Rd

Filed JUN 26 1922 191..... ROBERT R. KNAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23, 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an with or Ind (Inquest, autopsy or inquiry.) June 24, 1914 thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull and Int injuries

Caused by fall from Elevator Shaft at Nursery Bldg (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

June 24 1914 (Address) ..... 1633 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Linden Park — DATE OF BURIAL, 6/26..., 19 22

20-UNDERTAKER Philip Henrig — ADDRESS 2016 Aiken St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65429

CERTIFICATE OF DEATH.

X 44 D 65429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME William Fleetwood

(a) RESIDENCE NO. Lutherville Md ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Corresponding with Mrs Alice Fleetwood 1926 Fairfield Ave

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardner 186

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer Mr Weller

9 BIRTHPLACE (city or town) Penna (State or country)

PARENTS

10 NAME OF FATHER John Fleetwood

11 BIRTHPLACE OF FATHER (city or town) Penn (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Penn (State or country)

14 Informant Chas Fleetwood (Address) 2121 Ridgewood av

15 FILED JUN 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1922, to June 23, 1922, that I last saw him alive on June 23, 1922, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinomatosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel J Levegood M.D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 26 1922

20 UNDERTAKER: John Fields 1200 W Lombard — ADDRESS

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65430

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 / D 65430

REGISTERED No. C.....

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Eutaw St. McMinans St.; 25 WARD)

2-FULL NAME Catherine Hill

(Residence in Baltimore: No. Eutaw st McMinans St.; ..... yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female | 4-COLOR OR RACE: colored | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: January (Month) 23 (Day), 1898 (Year)

7-AGE: 24 yrs. 5 mos. 0 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: Joseph Houston

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Nettie Wolford

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace Hill

(Address) Eutaw st

15- Filed JUN 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 23 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1922 to June 23 1922, that I saw her alive on June 22, 1922 and that death occurred, on the date stated above, at 4-30 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) ..... yrs. 4 mos. ..... ds

Contributory (SECONDARY) same (Duration) ..... yrs. 4 mos. ..... ds.

(Signed) Geo L McKeever M. D.

June 24, 1922 (Address) 2320 Washington Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn cemetery | DATE OF BURIAL: June 26 1922

20-UNDERTAKER: Edward Ringgold | ADDRESS: 463 N. Carey [illegible] Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65431

CERTIFICATE OF DEATH.

129

D 65431

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 S. Payson ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Hipsley

(a) RESIDENCE NO. 5 S. Payson ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, ~~Married~~, Widowed, or ~~Divorced, (write the word)~~: widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Hipsley

6 DATE OF BIRTH (month, day, and year): July 3 1857

7 AGE: Years 64 Months 11 Days —

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Washington Co md

PARENTS

10 NAME OF FATHER: Henry Knott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington Co md

12 MAIDEN NAME OF MOTHER: Adamana Hetrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington Co md

14 Informant: Anna Hipsley

(Address): 5 S Payson st

15 Filed JUN 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to June 24, 1922, that I last saw her alive on June 23, 1922 and that death occurred, on the date stated above, at 6 40 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Bright's

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill, M. D.

6/25 1922 (Address) 108 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: June 27 1922

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 2178 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65432

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Preston Apartments ST., 11 WARD)

2-FULL NAME William F. Pirscher

(a) RESIDENCE NO. Preston & Guilford Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO. 101 D 65432

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE LEGIBLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude A Pirscher

6 DATE OF BIRTH (month, day, and year) July 13. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at law

(b) General nature of Industry, business, or establishment in which employed (or employer) 042

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William F. Pirscher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Hett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Gertrude A. Pirscher
(Address) Preston Apartments

15 Filed JUN 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15. 1922. to Jun 23. 1922
that I last saw h alive on Jun 22. 1922.
and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Grippe & Lobar pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [redacted]

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas F Bloh, M. D.

June 1922 (Address) 20 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 26 1922

20 UNDERTAKER Chas O. Mitchell — ADDRESS 201 N. Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65433

CERTIFICATE OF DEATH.

44 D 65433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Linden Ave. ST., 11 WARD)

2-FULL NAME Harriet Olivia Brooke

(a) RESIDENCE NO. 1302 Linden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin E.P.Brooke

6 DATE OF BIRTH (month, day, and year) Sept.8.1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cockeysville Md.

PARENTS

10 NAME OF FATHER David T. Montsarrat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet O.Ruffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth P. Jones (Address) Hotel Sherwood

15 Filed JUN 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24. 1922

17 I HEREBY CERTIFY, That I attended deceased from April 14th, 1922, to June 23rd, 1922, that I last saw h er alive on June 23rd, 1922, and that death occurred, on the date stated above, at 1.35 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Pyloric end of Stomach)

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) None that I know of.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearn, M. D.

June 24, 1922 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 26 1922
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 N. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1775 65434

REGISTERED NO.

65434

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Mulliken ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Banka

(a) RESIDENCE. NO. 1608 Mulliken ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Josephine Banka

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: 70 Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer): Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dorchester Co

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Annie Banka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester Co

14 Informant: Josephine Banka

(Address) 1608 Mulliken St

JUN 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1922, to June 23, 1922,

that I last saw him alive on June 22, 1922,

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) Cardiac Muscular Sclerosis

(duration) ... yrs. ... mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

, 19 (Address) 1429 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 27 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Av

mation should be carefully supplied. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65435 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65435

CERTIFICATE OF DEATH.

REGISTERED NO. 25-31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 577 Maryland ave Brooklyn WARD 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Morris D. Kluttz

(a) RESIDENCE. No. 577 Maryland ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie A. Kluttz

6 DATE OF BIRTH (month, day, and year) Oct 12 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md. Pie Co.

9 BIRTHPLACE (city or town) (State or country) Salisbury N. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sallie A. Kluttz (Address) 577 Maryland ave

15 Filed JUN 26 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 5, 1922, to June 24 1922, that I last saw h[illegible] alive on June 24, 1922, and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 10 mos. ds.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) J. F. Hagerty M. D.

6/24 1922 (Address) 16 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va DATE OF BURIAL June 26 1922

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65436

D 65436

CERTIFICATE OF DEATH.

90

REGISTERED NO. C .....

PLACE OF DEATH

CITY OF BALTIMORE (No. Church Home ST. 17 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Gustave Simonson

(Residence in Baltimore: No. Normandie Apartments St. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: April 1, 1862 (Month) (Day) (Year)

7-AGE: 60 yrs. 2 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Architect
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Dresden-Germany

PARENTS.

10-NAME OF FATHER: David Simonson

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Louise —

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucius White Jr

(Address) 5 E Hoffman Ave

15-

Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

JUN 26 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June 24, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) 1 yrs. ....mos. ....ds.

(Signed) J. S. Fisher M. D. (Coroner.)

6-25, 192.. (Address) 508 E. Hoffman Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, June 26 1922

20-UNDERTAKER Wm. J. Packard Sons — ADDRESS 22 Monroe St.

N. B.—Every item of information should be carefully supplied. AGE, name of City and DATE OF DEATH must be given. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65437

D 65437

CERTIFICATE OF DEATH.

REGISTERED NO. 139

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1904 N. Monroe ST.; 15 WARD)

2-FULL NAME Harry J. Holland

(a) RESIDENCE. NO. 1904 N. Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of Anna E Holland

6 DATE OF BIRTH (month, day, and year) August 23-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Telephone Co.

(c) Name of employer C & P. Tele Co

9 BIRTHPLACE (city or town) (State or country) Shrewsbury York Co. Pa

PARENTS

10 NAME OF FATHER Geo Holland

11 BIRTHPLACE OF FATHER (city or town) Shrewsbury (State or country) York Co. Pa

12 MAIDEN NAME OF MOTHER Margaret Kohler

13 BIRTHPLACE OF MOTHER (city or town) Shrewsbury (State or country) York Co. Pa

14 Informant Anna E Holland (Address) 1904 N. Monroe St

15 Filed JUN 2 6 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1922, to June 24th, 1922, that I last saw h im alive on June 24th, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of the Liver

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? This home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopic.

(Signed) Wm J Sullivan, M. D.

6/26, 1922 (Address) 1701A Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	June 27 1922

20 UNDERTAKER Hasbrook Sons ADDRESS 1827 W North Ave

MATION should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 65438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65438

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) #2729 Fox ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard F Jordan

(a) RESIDENCE NO. #2729 Fox ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12 1922

7 AGE — Years: — Months: 1 Days: 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Balto City Md

PARENTS

10 NAME OF FATHER: Wm H Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Wollenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm H Jordan

(Address): 2729 Fox St

15 Filed JUL 2 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to June 25, 1922, that I last saw him alive on June 21, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Signs Physician

What test confirmed diagnosis?

(Signed) C E Normant M. D.

June 25 1922 (Address) 3547 Chestnut St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: June 26 1922

20 UNDERTAKER: Chenoweth & Son — ADDRESS: Chestnut St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

156490 D 65439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001
D 65439

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 12 WARD)

2-FULL NAME Helen Cornett

(a) RESIDENCE NO. 2221 Guilford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) June 11-22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child ppp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Harry Cornett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUN 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1922, to June 24, 1922, that I last saw h— alive on June 24, 1922, and that death occurred, on the date stated above, at 7.50 P.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. mos 13 ds.

CONTRIBUTORY (Secondary) X (duration) ..... yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H H Veach M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents

DATE OF BURIAL June 26 1922

20 UNDERTAKER Leo G. Cook

ADDRESS Northumberland

N. B.—WRITE PLAINLY, with ink. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that information is carefully supplied. AGE should be carefully stated. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65440

CERTIFICATE OF DEATH.

113 D 65440

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 St Paul Ave St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Slayman

(Residence in Baltimore: No. 620 St Paul's ave St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, March (Month) 15 (Day), 1922 (Year)

7-AGE, yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9-BIRTHPLACE, (State or Country). 620 St Paul's Ave

PARENTS.

10-NAME OF FATHER, Melvin Slayman

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Irene Yingling

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. A. Slayman

(Address) 620 St Paul's Ave

15-

Filed ....., 191.. ROBERT R. KRAUTER,

JUN 26 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 26th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 1922, to June 25 1922, that I saw her alive on June 24th 1922, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) A. Adam Tod M. D.

....., 191... (Address) 4704 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	June 25th, 1922
20-UNDERTAKER Leo G. Lord	ADDRESS North & Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65441

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65441

CERTIFICATE OF DEATH.

K 49

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Junius Woods

(a) RESIDENCE. NO. Hagerstown ST., Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER J. T. Woods

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Florence Trush

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Records
(Address)

15 Filed , 19 Registrar

JUN 2 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to June 26, 1922, that I last saw h[illegible] alive on June 25, 1922, and that death occurred, on the date stated above, at 5-40 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left Knee

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hagerstown Md.

Did an operation precede death? Yes Date of May 12, 1922

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Vincent Godfrey, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	June 26 1922
20 UNDERTAKER	ADDRESS
W. M. Routson	2230 N. Mitt

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 65442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65442

5 179

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 110 Colvin St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Jackson

(Residence in Baltimore: No. 110 Colvin St.; yrs. 40 mos. ds.)

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Unknown 1882
(Month) (Day) (Year)

7-AGE. 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 137

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Jackson

(Address) 110 Colvin

15- JUN 2 1922 192 M.7.a Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dom Bron - may have been Valv dis heart
may have been Nephritis -
Said to be Hemorrhage of al colvin
Dom Bron (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastritis
Dom Bron (Duration) yrs. mos. ds.

(Signed) Markley M. D.
(Coroner)
June 26 192 (Address) 1059 Druid

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Laurel Cemetery June 26 1922

20-UNDERTAKER. ADDRESS.
Chas. H. Lindenmeyer 746 N. Carlton St

Spec.—1-10-21—M&T—1500 Bks.

D 65443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65443

CERTIFICATE OF DEATH.

X 148

REGISTERED NO. .....

1-PLACE OF DEATH Church Home and Infirmary.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 6 WARD)

2-FULL NAME Frances Gladden Nimmo

(a) RESIDENCE NO. Towson, Maryland ST., ... WARD Towson Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. 5 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sidney T. Nimmo Jr.

6 DATE OF BIRTH (month, day, and year) May 8-1886.

7 AGE	Years	Months.	Days	If LESS than 1 day, ... hrs. or ... min.
36		1.	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Harford Co. (State or country) Maryland.

PARENTS

10 NAME OF FATHER Frank Gladden

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Virginia Hewett

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant (Address) E. T. Nimmo Jr.

15 Filed ..... 19 ..... Registrar

Buried Forest Glade

Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1922, to June 26, 1922, that I last saw her alive on June 26, 1922, and that death occurred, on the date stated above, at 8.23 a. m.

The CAUSE OF DEATH* was as follows:

Nephritic toxaemia of pregnancy. with convulsions at 6th month.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) acute cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 22 1922

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) John G. Nimmo Jr. M. D.

June 6 1922 (Address) 1107 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem, Harford Co. DATE OF BURIAL 6/28, 1922

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert

2 1922

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Pugliese) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65444

CERTIFICATE OF DEATH.

113

D 65444

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Fawn ST., 3 WARD)

2-FULL NAME Antonietta Josephina Pugliese

(a) RESIDENCE NO. 902 Fawn st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 22-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Antonio Pugliese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Barbarino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mother of Child (Address) Baltimore Md.

15 Filed JUN 12 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to June 25, 1922, that I last saw her alive on June 25, 1922, and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Convulsion of infants
Acute Gastro-intestinal

..... (duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Nicholas P. Lombardi, M. D.

, 19 (Address) 232 S. High St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 26 1922
20 UNDERTAKER	ADDRESS
Martin W. J. Dyer	37 S. Am. St.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

15 6695
D 65445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 60 001
D 65445

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Palmer Brown

(a) RESIDENCE NO. 15 Cottage Place, ST., WARD Utica, N.Y.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Sept. 1-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	40	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Grace Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Margaretta Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 [illegible] 1922 . 19 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25-22

17 I HEREBY CERTIFY, That I attended deceased from June 21st. 19 22 to June 25-22. 19 22.

that I last saw h alive on June 25-22. 19 22

and that death occurred, on the date stated above, at 11.30 P.M.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Embolus cerebral(?) coronary(?) 10 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of June 21, 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. W. Zumwinkle, M. D.

6-25-22 . 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Utica N.Y. Cremation

DATE OF BURIAL 6/26/22

20 UNDERTAKER H. E. Snyder

ADDRESS 1-5 W. 54th Broadway

N 26 1922

8. WRITE plainly, be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65446

CERTIFICATE OF DEATH.

D 65446

REGISTERED NO. 4 X 117

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Allen.

(a) RESIDENCE. No. Onancock, Va. ST., ... WARD. Onancock Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 9. ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ (or ~~WIFE~~ of ~~HUSBAND~~ of): Herman Allen

6 DATE OF BIRTH (month, day, and year): 1896.

7 AGE: Years 26. Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Elisha Crockett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mamie Crockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hospital Record
(Address)

15 JUN 25 1922, 19 ... Registrar: Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/25 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/16, 1922, to 6/25, 1922.

that I last saw h[illegible] alive on 6/25, 1922

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis
General Peritonitis

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary): Inanition

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 6/16/22.
no

Was there an autopsy? ...

What test confirmed diagnosis? clinical findings

(Signed) Iron Irvin, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crisfield Md. DATE OF BURIAL: July 26 1922

20 UNDERTAKER: Harry H. Witzke ADDRESS: 1531 W Lombard

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65447

CERTIFICATE OF DEATH.

32 D 65447

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Miss Catharine Miller

(a) RESIDENCE NO. 322 S. Gilmor St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore —

PARENTS

10 NAME OF FATHER John W. Miller

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma V. Kaiser

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant John W. Miller (Address) 322 S. Gilmor

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

JUN 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 22nd, 1922, to June 26th, 1922, that I last saw her alive on June 26th, 1922 and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculer Meningitis

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Failure Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed djagnosis? Clinical & Lab.

(Signed) C. G. Caldwell, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 28 1922

20 UNDERTAKER Harry N. Witzke — ADDRESS 1531 W Lombard St

G. B.—WRITE PLAINLY and have all information supplied. AGE should be stated EXACTLY. PHYSICIANS and others should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.- 1-10-21 - M&T - 1500 Bks.

D 65448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65448

CERTIFICATE OF DEATH.

51

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 Lorraine Av ST., 17 WARD)

2-FULL NAME Mildred F. Payne

(a) RESIDENCE NO. 418 Lorraine Av ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 3 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER Abram Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Farver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Abram Payne (Address) 418 Lorraine Ave

15 Filed ....., 19 ..... Registrar

Robert P. Harrison,

JUN 26 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from April 8th, 1922, to June 25th, 1922.

that I last saw h[illegible] alive on June 24th, 1922.

and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever

(duration) — yrs. — mos 28 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Hubert F. Kellman M. D.

, 19 (Address) 1227 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL June 27 1922

20 UNDERTAKER H. M. Cook — ADDRESS 1848 W. N.

mation should be carefully supplied. AGE should be stated EXACTLY. Fractions of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 65449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65449

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 S. Bond ST., 3 WARD)

2-FULL NAME Edward Rychwalski

(a) RESIDENCE NO. 732 S. Bond ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 11-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Philip Rychwalski

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Josephine Lampka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Philip Rychwalski

(Address) 732 S Bond St.

15 Filed ..... 19 .....

Registrar

N 2 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1922

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1922, to June 25, 1922.

that I last saw him alive on June 24, 1922

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Tumbleson M. D.

6/26 1922 (Address) 2013 Banks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL June 29 1922

UNDERTAKER W. F. Gaylowski ADDRESS 1618 Easter

IMPORTANT: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65450

47

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Penna. Ave ST.; 13 WARD)

2-FULL NAME Jennie Sommerfeld

(a) RESIDENCE. NO. 3107 Penna. Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isador Sommerfeld

6 DATE OF BIRTH (month, day, and year) Mar 6 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Aaron Greenhood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Greenhood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Jerome Sommerfeld 3107 Penna Ave

15 Filed ..... 19 ..... Registrar

JN 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1921, to June 23rd 1922, that I last saw h alive on June 22 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Brain Embolism

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/22/1920

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Harry Goldberg, M. D.

(Address) 3210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ohel Shalom Cemetery	June 27/1922

20 UNDERTAKER J. Ahrens & Co. ADDRESS 1611 Madison Ave

NOTE.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Ligamon)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65451

D 65451

146

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 76 WARD)

2-FULL NAME Mrs Betty Ligamon

(a) RESIDENCE NO. 4809 Eastern Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Nick Ligamon

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 38 yrs. Months 5 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Andrew Ligamon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Marie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Nick Ligamon (Address) 4809 Eastern Ave

15 Filed . 19 Registrar Robert T. Harrison, Burial Permit Clerk.

6 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19. 1922 to June 25 1922

that I last saw her alive on June 25 1922 7.10 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chest Cancer.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Puerperal Sepsis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. J. Lowenstein M.D.

. 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL 6/27/22

20 UNDERTAKER Geo A Farley Suttor ADDRESS Fayette

NOTE.—Information should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be used. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65452

CERTIFICATE OF DEATH.

REGISTERED NO. 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2064 Linden Ave ST., 14 WARD)

2-FULL NAME Sarah Heller

(a) RESIDENCE NO. 2064 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lussman Heller

6 DATE OF BIRTH (month, day, and year): May 5th 1838

7 AGE: Years 87 Months 1 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Samuel Wallach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germ

14 Informant (Address): J Heller 2064 Linden Ave

15 Filed JUN 26 1922, 19 Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1922, to June 26, 1922, that I last saw h alive on June 26, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Hemiplegia)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P Heubruger, M. D.

June 26, 1922 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C.

DATE OF BURIAL: 6/27 1922

20 UNDERTAKER: Wm J Goudheim

ADDRESS: 118 N Royal St

1. WRITE PLAINLY with pen and ink and use only figures and words carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in answering the questions relating to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65453

CERTIFICATE OF DEATH.

129 D 65453

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.) 8 (WARD)

2-FULL NAME Anna Kelly

(a) RESIDENCE NO. 1517 N. Bond St (ST.) WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1860

7 AGE | Years 62 | Months — | Days — | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ppp

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Hand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Katie Kelly

(Address) Riderswood Md.

Filed JUN 26 1922, 19 Robert P. Harrison, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to June 26, 1922, that I last saw her alive on June 25, 1922, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Cong

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) S. W. Kourey, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery | DATE OF BURIAL June 28 1922

20 UNDERTAKER Chas. H. Evans & Son | ADDRESS 118 W. Mt Royal Ave

—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should be careful and accurate in stating AGE and OCCUPATION. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65454

D 65454

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2736 Reisterstown Road ST.) 15 (WARD)

2-FULL NAME Eliza Jane Roberts

(a) RESIDENCE. NO. 3736 Reisterstown Road ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~divorced~~ ~~Husband of~~ WIFE of William C. Roberts.

6 DATE OF BIRTH (month, day, and year) Feb 9-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Cornelius C Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Nicoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Wm C. Roberts (Address) 3736 Reisterstown Rd.

Filed ..... 19 ..... Registrar

JUN 26 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 1922 to June 24 1922

that I last saw her alive on June 24 1922

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: (a) Progressive Pernicious Anaemia

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) N. L. Duckiell M. D.

19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 27 1922

UNDERTAKER — ADDRESS: Chas. F. Fraser & Son 1118 W. Royal ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65455 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65455

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9P Castle ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Arthur Earles Jr.

(a) RESIDENCE NO. 9P Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 13-1921

7 AGE: Years 1; Months 1; Days 12.

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John A. Earles.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Florence E. Heak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: John A. Earles Jr (Address) 9P Castle St

15 Filed ..., 19 ... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to June 26, 1922, that I last saw h[illegible] alive on June 25, 1922, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Bronchio Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 9P Castle St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Ephraim, M. D.

, 19 (Address) 1946 East St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 27 1922

20 UNDERTAKER: Jas L Miller — ADDRESS: 2330 Jeffer[illegible] St

6 26 1922

S. B.—WRITE plainly and carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65456

CERTIFICATE OF DEATH.

D 65456

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 Edgewood ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. John Ward Willson

(a) RESIDENCE. NO. 2100 Edgewood ST., 15 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 77 yrs. 8 mos. 11 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Eugenia Willson

6 DATE OF BIRTH (month, day, and year) October 13 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Physician

(b) General nature of industry, business, or establishment in which employed (or employer) and Instructor B.P.L.

(c) Name of employer Self & City of Balti. When Employed

9 BIRTHPLACE (city or town) Syracuse

(State or country) New York

PARENTS

10 NAME OF FATHER John Ward Willson

11 BIRTHPLACE OF FATHER (city or town) Harrisburg

(State or country) Penna.

12 MAIDEN NAME OF MOTHER Fayette Medcinz

13 BIRTHPLACE OF MOTHER (city or town) Harrisburg

(State or country) Penna.

14 Informant Mrs Jos. L Lacey (daughter)

(Address) 406 E 71st Brooklyn N.Y.

15 JUN 27 1922 ROBERT R. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 24, 1922, that I last saw him alive on June 24, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Purulent Bronchitis with chronic myocarditis, (senile) of several years standing

Duration yrs. ? mos. — ds.

CONTRIBUTORY (Secondary) Pleurisy with pulmonary congestion and heart failure

Duration yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J Wesley Call M. D.

6/26 1922 (Address) 2202 Gorsuch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL June-27 1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODS, Manager)

ADDRESS 1 W. NORTH AVE.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 65457

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65457

CERTIFICATE OF DEATH.

REGISTERED NO. 11 X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1112 Division ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Edwards

(a) RESIDENCE. NO. 1112 Division ST., WARD Sotterley N. Mary's Co.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co Md.

PARENTS

10 NAME OF FATHER Frank Jenifer

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James Clark (Address) 1114 Division St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25th, 1922 to June 23rd, 1922

that I last saw her alive on June 23rd, 1922

and that death occurred, on the date stated above, at 4.00 A m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

Chronic Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystadenoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. H. Lautenbach M. D.

June 24 1922 Address 2215 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mill Stone Wharf St Mary's Co

DATE OF BURIAL: June 26 1922

20 UNDERTAKER: Joseph A Farrell

ADDRESS: 2814 Dunkirk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65458

D 65458

CERTIFICATE OF DEATH.

REGISTERED NO. C 70

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hosp. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Darling Clark.

(Residence in Baltimore: No. 5342 Pine St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 29, 1917
(Month) (Day) (Year)

7-AGE, 4 yrs. 3 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE. (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER John Clark

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mable Berry

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Mable Clark

(Address) 5342 Pine St.

15- ROBERT R. KRAUER, 191... Registrar.

JUN 27 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) J. Bart Cole M. D.
(Coroner.)

6-26 1922 (Address) 1118 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Md Cemetery

DATE OF BURIAL, June 27, 1922

20-UNDERTAKER David Easton

ADDRESS 916 Park Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65459

CERTIFICATE OF DEATH.

113 D 65459

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 Otterbein ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Goodwin

(a) RESIDENCE NO. 224 Otterbein ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 10, 1922

7 AGE Years — Months 7 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER George Goodwin

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Goodwin

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant George Goodwin (Address) 224 Otterbein St

15 Filed JUN 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to June 26, 1922, that I last saw h. alive on June 25, 1922, and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. T. Howell M. D.

6/26 1922 (Address) 1198 Cambridge Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL June 27 1922

20 UNDERTAKER David Easton | ADDRESS Balto

N. B.—WRITE PLAINLY, WITH CONSIDERABLE CARE. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65460

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Harris

(a) RESIDENCE. No. 1257 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Wife of Ernest W. Harris

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 37 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Michael Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Muller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Interment (Address): Hospital Records

15 Filed JUN 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to June 26, 1922, that I last saw her alive on June 25, 1922, and that death occurred, on the date stated above, at 2.07 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastases to other breast and liver

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1257 N. Broadway

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Vincent Dobbs M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetary — DATE OF BURIAL: June 29 1922

20 UNDERTAKER: Michael Doyle — ADDRESS: 15 E Lee St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 65461

D 65461

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Asia Mason ST.: 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. 127 White St.

(a) RESIDENCE. NO. 127 Monta St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. Information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Horace Ruggold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Williams

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Anna Miller
(Address) 537 Orchard st

15 Filed JUN 27 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to June 23, 1922, that I last saw her alive on June 23, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. D. Quick, M. D.

19 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct. | DATE OF BURIAL: June 27 1922

20 UNDERTAKER: S. L. Brown & Son | ADDRESS: 1211 Monta

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65462

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Davis

(a) RESIDENCE. No. 11 W. York st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Davis

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Sam Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Laura Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records M.T.H.

15 Filed JUN 27 1922, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1922, to June 26, 1922, that I last saw him alive on June 26, 1922, and that death occurred, on the date stated above, at 5.35 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and Enteritis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dadaylacco M.D.

6-26, 1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: June 28 1922

20 UNDERTAKER: N. E. Brown & Son

ADDRESS: 1011 Monty

N. B.—Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65463

CERTIFICATE OF DEATH.

74-81 65463

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 823 N. Carrollton Ave ST.; 16 WARD)

2-FULL NAME Mary Gilmore

(a) RESIDENCE. NO. 823 N. Carrollton Ave ST.; WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single, Married~~, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Robert Gilmore

6 DATE OF BIRTH (month, day, and year) — 1844

7 AGE Years 78 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Alexander Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Jennie. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Reed (Address) 526 N. Linwood Ave

15 Filed JUN 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9 - 1920 to June 26 - 1922, that I last saw her alive on June 26 - 1922, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy & Right Hemiplegia

Duration Forty (40) Months

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Carlton H. Cook, M. D.

June 27, 1922 (Address) 1107 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL June 28 1922

20 UNDERTAKER Gilliam & Fox ADDRESS 1723 W. Lafayette Ave

N. B.—WRITE PLAINLY, with ink. All information should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 65464

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3209 N. Charles St ST., 11 WARD)

2-FULL NAME Nina Harding Warfield

(a) RESIDENCE NO. 10 E. Madison St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24, 1867

7 AGE: Years 55 Months 2 Days 2

If LESS than 1 day, ... hrs. or .. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas W. Warfield

11 BIRTHPLACE OF FATHER (city or town) Howard Co Md

12 MAIDEN NAME OF MOTHER Rebecca Frail

13 BIRTHPLACE OF MOTHER (city or town) Fred. Md

14 Informant Dr. W. D. Stone

(Address) 3209 N. Charles St

15 JUN 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, that I attended deceased from Oct. 1920, to June 26, 1922, that I last saw h[illegible] alive on June 26, 1922 and that death occurred, on the date stated above, at 805 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis - cachexia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Sept. 1920

Did an operation precede death? yes Date of Feb 1922

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Walter D Stone, M. D.

, 19 (Address) 1800 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md. DATE OF BURIAL June 28 1922

20 UNDERTAKER John A Mitchell ADDRESS 201 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65465

5/ D 65465

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1309 Druid Hill Av. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Woods

(a) RESIDENCE. No. 1309 Druid Hill Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Wesley J Wood

6 DATE OF BIRTH (month, day, and year) — — 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Genl Work

(c) Name of employer Mrs Butz

9 BIRTHPLACE (city or town) (State or country) Warrenton Va

PARENTS

10 NAME OF FATHER James Hatton

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Virginia

12 MAIDEN NAME OF MOTHER Julia Lee

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Virginia

14 Informant Sybil Brown (Address) Warrenton Va

15 Filed JUN 27 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17th, 1922, to June 26th, 1922, that I last saw her alive on June 25th, 1922, and that death occurred, on the date stated above, at 9.25 A m.

The CAUSE OF DEATH* was as follows:

Senile Arterial Rheumatism

& Nephritis (duration) — yrs. One mos. — ds.

CONTRIBUTORY (Secondary) Senile Myocarditis (duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edward Eckenrode, M. D.

June 26 1922 (Address) 1339 N North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Warrington Va — DATE OF BURIAL June 29 1922

20 UNDERTAKER Samuel J Wensley — ADDRESS 1 E Biddle

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 65466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65466

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Church.

City of BALTIMORE: (No. 214 W. Hamburg St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Reason. (C)

(Residence in Baltimore: No. 158 W. West St. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: Colored.

5-Single, Married, Widowed or Divorced, (Write the word.): Widower.

6-DATE OF BIRTH: Do not know. (Month) (Day) (Year)

7-AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Minister of the
(b) General nature of Industry, business, or establishment in which employed (or employer): Gospel. 018

9-BIRTHPLACE, (State or Country): Kent Co. Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Idella C. Washington. (C) granddaughter.

(Address) 2020 Titan St. Philadelphia, Pa.

15- JUN 27 1922 192 ROBERT R. KRAUTER, Registrar.

Burial Permit CHK.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23rd. 1922. (Month) (Day) (Year) 192

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

June 25 1922 (Address) 10 17 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, June 27 19 22

20-UNDERTAKER, John H. Toadvine ADDRESS 142 Justice St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Wm Fountain

D 65467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65467

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 249 N. Schroeder St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Fountain

(Residence in Baltimore: No. 249 N. Schroeder St St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: colored

5-Single, Married, Widowed or Divorced, (Write the word.): Sigle

6-DATE OF BIRTH: Dont Know (Month) (Day) (Year)

7-AGE: 44 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Balt Md

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER, (State or Country): Dont Know

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country): Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Tyler

(Address) 249 N. Schroeder St

15- JUN 27 1922 Filed 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June 26 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. Dont Know mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. K. Gorsuch M. D.
(Coroner.)

June 27 1922 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: June 28 1922

20-UNDERTAKER: Thomas Fineran

ADDRESS 614 N. Schroeder St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 65468

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1157 ward St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Margaret G. Embe

(Residence in Baltimore: No. 1157 ward St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	S

6-DATE OF BIRTH, Feb (Month) 17 (Day) 1918 (Year)

7-AGE, 4 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Harrison C Embe

11-BIRTHPLACE OF FATHER, (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Carrie Letterman

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harrison C. Embe

(Address) 1157 ward St

15- Filed JUN 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 25 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

3° Burns on R side of Body, while playing Stabbing & mated

(Duration) .....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) James H Taylor M. D. (Coroner.)

June 26, 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? ward St

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mathews — DATE OF BURIAL, 6/28, 1922

20-UNDERTAKER, W. J. Tschudy & Son — ADDRESS North Penn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65469

CERTIFICATE OF DEATH.

-100-00

D 65469

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Custis

(a) RESIDENCE. No. 1565 Leslie st. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cornelia Custis

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Ben Custis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maggie Ames

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) M.C.H.

15 Filed JUN 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to June 24, 1922, that I last saw him alive on June 24, 1922, and that death occurred, on the date stated above, at 12.55 p. m.

The CAUSE OF DEATH* was as follows:

Sub-phrenic abscess, which ruptured thru the diaphragm

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Francis L Dalyrimple M. D.

6-24-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cemetery	June 28 1922
20 UNDERTAKER James H. Dennis	ADDRESS, 207 Gunston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ethridge

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65470

CERTIFICATE OF DEATH.

31 D 65470

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 N Mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Ethridge

(a) RESIDENCE. No. Balto md ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20 yrs.	1 mo.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER John Ethridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Eggie Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Elizabeth Ethridge
(Address) 1315 N Mount St.

15 Filed JUN 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 4-1- 1922, to 6-25- 1922, that I last saw h[illegible] alive on 6-20- 1922, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Boykins, M. D.

, 19 (Address) 1018 N Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dale Chuch. A. C.	June 28 1922
20 UNDERTAKER James H. Dennis	ADDRESS, 30[illegible] Greenmount

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65471

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. St. (Ward) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie M Mauck.

(a) RESIDENCE No. 865 Harlem Ave St., City Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (or) WIFE of James W Mauck (husband)

6 DATE OF BIRTH (month, day, and year) Sept. 24, 1876

7 AGE: Years 45 Months 9 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry P. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emily Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 JUN 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 26 1922, that I last saw h[illegible] alive on June 26, 1922, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease: Myocardial failure Auricular fibrillation.

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Electrocardiogram.

(Signed) C. Sidney Burwell, M. D.

JUN 26 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park DATE OF BURIAL JUN 28 1922 19

20 UNDERTAKER Geo W. Little ADDRESS 2100 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65472

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Wilkins ave ST., 70 WARD)

2-FULL NAME Herman B. L. Evelding

(a) RESIDENCE No. 2203 Wilkins ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 73 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer must be filled in. Every question answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 9th 1843

7 AGE: Years 78 Months 6 Days 16 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Mfr

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Christian Evelding

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lorit Thron

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: G. F. Booke

(Address) 217-a Equitable Bldg

15 Filed JUN 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25th 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922, to June 26, 1922, that I last saw him alive on June 26, 1922, and that death occurred, on the date stated above, at 1150 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dropsy

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. M. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presbyterian Govans — DATE OF BURIAL: June 28 1922

20 UNDERTAKER: Geo. Weber & Son — ADDRESS: 2503 Edmondson ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ruffin

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65473 — 118 D 65473

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jannie Ruffin

(a) RESIDENCE. No. 1627 N. Bruce St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grant Ruffin

6 DATE OF BIRTH (month, day, and year) May 25-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) [illegible]
(State or country) [illegible]

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country)

14 Informant [illegible]
(Address) [illegible]

15 Filed JUN 27 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26 19 22

17 I HEREBY CERTIFY, That I attended deceased from 6-22, 19 22, to 6-26, 19 22, that I last saw h[illegible] alive on 6-26, 19 22, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Acute Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 6-26-22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1716 Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 29 1922
20 UNDERTAKER Edw Ruggold	ADDRESS
Mt Auburn	1463 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—[illegible] stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65474

CERTIFICATE OF DEATH.

100-001 D 65474

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1346 N Stricker ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A Sparks

(a) RESIDENCE NO. 1346 N. Stricker ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 27-1922

7 AGE — Years: | Months: 3 | Days: | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: William Sparks (Address) 1346 Stricker St

15 Filed JUN 27 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24 1922 to June 25 1922 that I last saw him alive on June 25 1922 and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

OTW

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr I S W Kennard, M. D.

6-26 1922 (Address) 708 Enson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: June 29 1922

20 UNDERTAKER: Edward Ruggold — ADDRESS: 1463 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mitchner

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 65475

D 65475

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709- Carr St ST., 19 WARD)

2-FULL NAME Elmer Mitchner Jr

(a) RESIDENCE No. 1709- Carr ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Elmer Mitchner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N. C.

12 MAIDEN NAME OF MOTHER Anna Bouyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sumters Co

14 Informant Elmer Mitchner
(Address)

15 Filed Robert P. Harrison, Registrar
JUN 27 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to June 27, 1922,
that I last saw him alive on June 27, 1922,
and that death occurred, on the date stated above, at 2.15 p. m.
The CAUSE OF DEATH* was as follows: Diarrhea and Enteritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Ct~~ Place of Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Exam
(Signed) Walter J. Proctor, M. D.
, 19 (Address) 1818 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL June 27 1922

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 1114 N. Gerard St

Spec.—1-10-21—M&T—1500 Bks.

D 65476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65476

CERTIFICATE OF DEATH.

37

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Monte Belle Terrace ST., 27 WARD)

2-FULL NAME Katherine S. Meiser

(a) RESIDENCE No. 102 Monte Belle Terrace ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Meiser

6 DATE OF BIRTH (month, day, and year) Feb 28, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George Wagner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth A. Green

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs Ruth Glenn (Address) 102 Monte Belle Terrace

15 Filed Jun 27 1922 19 Robert F. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1920, to June 25, 1922

that I last saw her alive on June 24, 1922

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cati's disease

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Eugene L. Peroa M. D.

6. 27. 1922 (Address) Jen Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL June 29, 1922

20 UNDERTAKER L. Sander Sons ADDRESS 1210 Fred St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65477

CERTIFICATE OF DEATH.

REGISTERED NO. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 616 Brook Ave. (St.) Rayburg (WARD) 27

2-FULL NAME Charles Osgood Pennington

(a) RESIDENCE No. 616 Brook Ave. (St.) Rayburg WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Pennington

6 DATE OF BIRTH (month, day, and year) March 16th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor 057

(b) General nature of industry, business, or establishment in which employed (or employer) Plasterer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER James Pennington

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emeline Lyon

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Elizabeth Pennington (Address) 616 Brook Ave. Rayburg

15 Filed JUN 27 1922 19 Robert P. Harrison, Registrar

Burial Permit Mark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1917, to June 25, 1922, that I last saw him alive on June 25, 1922 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Glosso-Labial Paralysis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lt. Hemiplegia; Arterio-sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Wilkinson M. D.

6/26, 1922 (Address) 13 Bel Air Rd, Rayburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 28 1922
20 UNDERTAKER Fredk Lissenden Sons	ADDRESS Fulberton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

JUN 27 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65478

CERTIFICATE OF DEATH.

REGISTERED NO. 133

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial ST.: Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis W. Hughes

(a) RESIDENCE. NO. New Bern, North Carolina

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL items must be stated. AGE should be carefully supplied. PHYSICIANS should be mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Hughes

6 DATE OF BIRTH (month, day, and year) Sept 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor of Medicine 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Isaac W. Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER M. McEachern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant T. C. Bond. (Address) 726 Resource St

15 Filed JUN 27 1922, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to June 27, 1922, that I last saw h[illegible] alive on June 27, 1922 and that death occurred, on the date stated above, at 11:44 P.M.

The CAUSE OF DEATH* was as follows:

Acute phlegmonous gastro-enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Papilloma of bladder

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? New Bern, N. C.

Did an operation precede death? Yes Date of 6-22-22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Gordon S. Seagrave, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Bern N. C. DATE OF BURIAL: June 27 1922

20 UNDERTAKER: A. J. Jenkins Co. ADDRESS: Cedar & Fremont Sts.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65479

CERTIFICATE OF DEATH.

D 65479

REGISTERED NO. C 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Orleans St. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud Johnson

(Residence in Baltimore: No. 1617 Orleans St. St. 64 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, unknown (Month) (Day), 1858 (Year)

7-AGE, 64 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): (3)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jackson Sims

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Nellie Harris

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Sims

(Address) 1617 Orleans St

15- JUN 27 1922 191.... Robert T. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 25, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23 1922, to June 25 1922, that I saw h[er] alive on June 25 1922, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Inflammation from tuberculous ovarian abscess (Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Tuberovarian abscess (Duration) yrs. 2 mos. ds.

(Signed) Richard O'Esterlicher M. D.

June 25 1922 (Address) 1514 Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cem. DATE OF BURIAL, June 26 1922

20-UNDERTAKER Milton Davis ADDRESS 315 N Eden St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65480

D 65480

CERTIFICATE OF DEATH.

9

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Eutaw ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph D. Eubanks

(Residence in Baltimore: No. 1023 N Eutaw St.; ..... yrs., 7 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October 29 (Month) (Day), 1914 (Year)

7-AGE, ... yrs. 7 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS:

10-NAME OF FATHER, Joseph Eubanks

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Eva Manlow

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Eubanks

(Address) 1023 N. Eutaw

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk, Registrar.

JA 27 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27th, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28th 1922, to June 27th 1922, that I saw h[illegible] alive on June 26th 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

About 4 mos (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. Patient mos. ..... ds.

(Signed) ..... M. D.

June 27th, 1922 (Address) 607 N Chapel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, June 7, 191.?

20-UNDERTAKER James H. Dunn

ADDRESS, 308 Greenmount

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65481

CERTIFICATE OF DEATH.

D 65481

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 N. Central ave. 9 WARD)

2-FULL NAME James O. Sapp.

(a) RESIDENCE No. 1311 N. Central ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Sapp.

6 DATE OF BIRTH (month, day, and year) Feb 15 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER James Sapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Leda Carlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mary Wade
(Address) 1311 N Central Ave

15 JUN 27 1922, 19

Robert P. Harrison,
Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to June 25, 1922, that I last saw h[illegible] alive on June 25, 1922, and that death occurred, on the date stated above, at 12 o'clock M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
DUR

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Brown Lewis, M. D.

6/26, 19 22 (Address) 1512 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 28 1922
20 UNDERTAKER	ADDRESS
William Cook	650 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS—and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No terminal hemorrhage.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Knipp Fremont + Lanvale

D 65482

CERTIFICATE OF DEATH.

57 D 65482

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 South Fremont St., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Tivis

(a) RESIDENCE NO. 805 South Fremont ST., WARD

(Usual place of nbode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: John Tivis

6 DATE OF BIRTH (month, day, and year): Jan 6-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Matthew Cavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Katherine Zeigfeld

(Address) St James Apartments

15 Filed ....., 19.... Robert P. Harrison, Registrar

JUN 27 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1922

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to June 25, 1922,

that I last saw her alive on June 25, 1922

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes and high blood pressure

about 5 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) H E Knipp M.D.

June 6, 1922 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 6/28 1922

20 UNDERTAKER: William Cook — ADDRESS: 502 C North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65483

CERTIFICATE OF DEATH.

46 D 65483

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2276 Fairmount Ave

2-FULL NAME Annie M Booley

(a) RESIDENCE No. 3227 E Fairmount Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Booley

6 DATE OF BIRTH (month, day, and year): Dec 31 1862

7 AGE — Years: 60 Months: 6 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of Industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Arthur Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Annie Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Raymond Booth

(Address) 3227 E Fairmount Ave

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1922

17 I HEREBY CERTIFY, that I attended deceased from Nov. 1-1921, 19 to June 26-1922, 19

that I last saw her alive on June 26-1922, 19

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix Uteri

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan-1922

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/27/22 (Address) 1919 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: June 28, 19 22

20 UNDERTAKER: Williambach — ADDRESS: 502 E Natl

JUN 27 1922, 19 Robert P. Harrison

Burial Permit Clerk

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65484

CERTIFICATE OF DEATH.

86-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Russell ST., 21 WARD)

2-FULL NAME Louis F. Pfeifer

(a) RESIDENCE NO. 1014 Russell ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	10	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) ppp

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Pfeifer

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Floyd

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant George Pfeifer
(Address) 1014 Russell st

15 ..... 19 ..... Registrar
Robert F. Garrison,
Burial Permit Clerk.

JUN 27 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/ 1922

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1922, to June 27, 1922
that I last saw him alive on June 27, 1922
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Otitis Media

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Raymond D. Allen, M. D.

....., 19 (Address) 1227 Colorado Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery | DATE OF BURIAL June 29 1922

20 UNDERTAKER James Dignan & Son | ADDRESS 1000 S Pica St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65485

CERTIFICATE OF DEATH.

D 65485

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 N. Vincent St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Boulding

(Residence in Baltimore: No. 1318 N. Vincent St.; yrs. 65 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

6-DATE OF BIRTH, about (Month) (Day) 1857 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. Boulding

(Address) 709 N. Bric St.

15-

FILED JUN 28 1922 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) no history.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. T. Hennessy, M. D.
(Coroner.)

June 22 1922 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND. DATE OF BURIAL, ... 19....

20-UNDERTAKER, ... ADDRESS 1922

MORGUE

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65486 **CERTIFICATE OF DEATH.** 161-001 D 65486

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. 1952 Ridgewood ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant son of Reuben & Emma Allen

(Residence in Baltimore: No. 1952 Ridgewood ave St.; ....yrs,....mos....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH June 27 (Month) (Day), 1922 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Reuben C Allen

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Emma Buckingham

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Reuben C Allen

(Address) 1952 Ridgewood ave

15- Filed JUN 28 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June 27 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 27 1922, to June 27 1922, that I saw h in alive on June 27 1922 and that death occurred, on the date stated above, at 1 9. m.

The CAUSE OF DEATH* was as follows:

Premature birth
(6 hours)
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) C E Nichols M. D.

June 27, 1922 (Address) Parkville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL, ..., 191...

20-UNDERTAKER Health Commissioner ADDRESS JUN 29 1922

19354

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65487 CERTIFICATE OF DEATH. 161-001 D 65487

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 854 Vine ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE. No. 854 Vine ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1922

7 AGE Years Months Days If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Norman Brown

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ethel Young

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Ethel Brown. (Address) 954 Vine St.

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to June 26, 1922, that I last saw him alive on June 26, 1922, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

6-26-1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUN 29 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

21

1932

Spec.—I-10-21—M&T—1500 Bks.

D 65488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 65488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Multberry ST., 4 WARD)

2-FULL NAME Josephine Watts

(a) RESIDENCE NO. 717 Multberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Philip Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jane Olins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Louis Grayson

(Address) 678 Aisquith

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/7 1922 to 6/26 1922

that I last saw h[illegible] alive on 6/26 1922

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pul. T. B. (duration) yrs. mos. 3 wks.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis M. D.

6/26 1922 (Address) 624 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 28 1922
20 UNDERTAKER	ADDRESS
Clement Hall	909 Hillen St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65489

CERTIFICATE OF DEATH.

D 65489

REGISTERED NO. 129

1-PLACE OF DEATH Municipal Hosp. 2.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Carrish

(a) RESIDENCE No. 16 2 f Millmore St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sydney Carrish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hosp. Records

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-21- , 1922, to 6-26 , 1922 that I last saw h. alive on 6-26- , 1922 and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

(Address) Municipal Hosp. 6/27 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL June 29 1922

20 UNDERTAKER Bros Robert A Elliott

ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65490

CERTIFICATE OF DEATH.

761-002

D 65490

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 9th & 2nd Ave Fairfield (St.) 25 (WARD)

2-FULL NAME Katherine Zientek

(a) RESIDENCE NO. 9th & 2nd Ave. Fairfield 25 ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years — Months — Days — If LESS than 1 day, ...hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Zientek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Katherine Lasek (June 7/26 1922)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Zientek (Address) Fairfield

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922 to — , 19 ,

that I last saw h.....alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Placenta Previa)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon Librorcap, M. D.

(Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a a Co — DATE OF BURIAL: 6-29 1922

20 UNDERTAKER: E & B Hasle — ADDRESS: 115 E West St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65491

CERTIFICATE OF DEATH.

159 D 65491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 S. Curley St. ST., 1 WARD)

2-FULL NAME James G. Ambrose

(a) RESIDENCE NO. 937 S. Curley St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 1922

7 AGE — Years | Months | Days: 4 | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Lorenzo Ambrose

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER Emma Gotha

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Lorenzo Ambrose (Address) 937 S. Curley St.

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to June 27, 1922, that I last saw h— alive on June 27, 1922, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace Fiston M. D.

6-27, 1922 (Address) 3N S. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: June 28 1922

20 UNDERTAKER: Selby & Zeller ADDRESS: 403 N. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

Thompson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65492

CERTIFICATE OF DEATH.

117 D 65492

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood ~~Hospital~~ ST., WARD)

2-FULL NAME Henry D. Thompson.

(a) RESIDENCE No. 804 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carmen E. Thompson

6 DATE OF BIRTH (month, day, and year) May 10-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer of. 140

(b) General nature of industry, business, or establishment in which employed (or employer) Silbert's Middy Blouse Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Charles H. Thompson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Idella F. Bangs 6-27-22

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Chas. H. Thompson (Address) 804 William

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6.27. 19 22

17 I HEREBY CERTIFY, That I attended deceased from 6.24.22, 19 , to 6.27.22, 19 .

that I last saw ~~him~~ alive on 6.27.22

and that death occurred, on the date stated above, at 8.05 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 804 William St.

Did an operation precede death? yes Date of 6.24.22

Was there an autopsy? yes

What test confirmed diagnosis? Clinical. Operation

(Signed) Philip D. Towles M.D.

6-27-22 19 (Address) 1433 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem — DATE OF BURIAL 6/29 1922

20 UNDERTAKER L. F. McCully — ADDRESS 130 E. Fort

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65493

D 65493

CERTIFICATE OF DEATH.

31

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 N. Clinton ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E. Cruddens

(Residence in Baltimore: No. 5 N Clinton St.; 46 yrs. 2 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH, April 19, 1876 (Month) (Day) (Year)

7-AGE, 46 yrs. 2 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Emma B. [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph E. Cruddens

(Address) 5 N. Clinton St.

15-

FILED JUN 28 1922 191.....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1922, to June 27 1922, that I saw h[illegible] alive on June 26 1922, and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Richard Eshleman M. D.

June 27, 1922 (Address) 25 W. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, June 29, 1922

20-UNDERTAKER Philip Herring — ADDRESS 2016 Orleans St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65494

CERTIFICATE OF DEATH.

X 60-001 D 65494

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital St.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Gladys Dimmock Turner

(a) RESIDENCE. NO. Union Memorial Hospital ST., 14 WARD. New York City.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? 36 yrs. 0 mos. 23 ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas Ashby Turner

6 DATE OF BIRTH (month, day, and year) June-5-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Talbott, County Maryland

PARENTS

10 NAME OF FATHER Charles Dimmock

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Rogers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Miss Natilie Dimmock, (sister)
(Address) 600-West-169th-St., N.Y. City

15 Filed ....., 19 .....
JUN 28 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1922, to June 28, 1922, that I last saw her alive on June 28, 1922, and that death occurred, on the date stated above, at 4:25 P.m.

The CAUSE OF DEATH* was as follows:

Erysipelas Gangrene

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) 11 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? New York City

Did an operation precede death? Yes Date of June 27, 1922

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Gordon K. Sprague, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
NEW YORK CITY.	June-28-22

20 UNDERTAKER MOWEN COMPANY
(WILLIAM F. WOOD[illegible])

ADDRESS 1[illegible] W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65495

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

D 65495

CERTIFICATE OF DEATH.

REGISTERED NO.....

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2623 Francis

CITY OF BALTIMORE: No. Baltimore, ST.: 13 WARD)

2-FULL NAME Ralph H. Nickels

(a) RESIDENCE. No. 2623 Francis ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? 62 yrs 2 mos. 19 ds

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Nickels

6 DATE OF BIRTH (month, day, and year): March 7th 1860

7 AGE — Years: 62 — Months: 2 — Days: 19 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry E. Nickels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Martha Koechl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: Carrie Nickels

(Address): 2623 Francis st

15 Filed ..... 19 JUN 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1921, to June 26, 1922, that I last saw h[illegible]alive on June 26, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Ind

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

Renal Insufficiency Indef

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Richardson M. D.

(Address) 1126 W. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: June 27 1922

20 UNDERTAKER: E Schloman & Son

ADDRESS 1034 Monroe

Spec.—6-9-19—H. P. Co.—1000 Bks.

Green ✓

D 65496 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 65496

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R. Green

(a) RESIDENCE. No. 2029 McCulloh ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 ~~Single, Married~~ Widowed, ~~or Divorced~~ (~~write the word~~) Widowed

5a ~~If married~~, widowed, ~~or divorced~~, HUSBAND of (or) ~~WIFE of~~ Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 39 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Duties

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Southern

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Southern

14 Informant Agnes Green (Address) 2029 McCulloch

15 Filed JUN 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to June 28, 1922, that I last saw h— alive on " 27, 1922 and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows: Valvular disease of Heart

Over

(duration) yrs. 4 mos. 18 ds.

CONTRIBUTORY (Secondary) Tumor Abdomen

(duration) yrs. 4 mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. T. Nelson M. D.

, 19 (Address) 1303 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Peter County — DATE OF BURIAL 6-30 1922

20 UNDERTAKER George H. Holland — ADDRESS 163 W Lexington

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non malignant.
Reported as T. B.
Mar. 27, 1922 by
Dr. Melvin.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65497

CERTIFICATE OF DEATH.

D 65497

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Maryland General Hospital ST. 19 WARD

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Omar Boyd.

(a) RESIDENCE. No. 1711 Edmondson Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maud R Boyd.

6 DATE OF BIRTH (month, day, and year) Sept 4, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	9	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Male

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mt. Carmel
(State or country) Maryland

PARENTS

10 NAME OF FATHER William B. Boyd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Margaret Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mrs. Maud R. Boyd
(Address) 1711 Edmondson Ave.

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to June 27, 1922, that I last saw h~~im~~ alive on June 27, 1922, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis, plus an acute pulmonary Infection.

(duration) yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 1711 Edmondson ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Mettauf, M. D.

June 28, 1922 Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 30 1922

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W. Baltimore St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Streptococcus infection.
Not tuberculosis.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65498

CERTIFICATE OF DEATH.

178 D 65498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 804 Appleton St. ST., 16 WARD)

2-FULL NAME John Frank Scott

(a) RESIDENCE NO. 804 Appleton St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie M. Scott

6 DATE OF BIRTH (month, day, and year) Aug. 14" 1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
48	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 766

(b) General nature of industry, business, or establishment in which employed (or employer) Palmer-Harvey Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Leitersburg (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Scott

11 BIRTHPLACE OF FATHER (city or town) Parkersburg (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Catherine J. Thiess

13 BIRTHPLACE OF MOTHER (city or town) Leitersburg (State or country) Md.

14 Informant Bessie M. Scott (Address) 804 Appleton St.

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26" 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to June 26 1922.

that I last saw h— alive on June 26, 1922,

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) W. G. Bigelow M. D.

June 27" 1922 (Address) 1405 EDMONDSON AVE

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL June 29 19 22

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Arthur G. Stayler

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 65499

D 65499

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2729 Fox ST.: 12 WARD)

2-FULL NAME Anthony - Geo. Stayler

(a) RESIDENCE. NO. 2729 Fox ST., 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 27/22

7 AGE — Years — Months — Days — If LESS than 1 day, 9 hrs. or min.

8 OCCUPATION OF DECEASED — 000

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anthony G. Stayler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Pearl Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Stayler
(Address) 2729 Fox St

15 JUN 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to June 28, 1922, that I last saw h alive on June 27, 1922 and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth
Sixth month.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) R. B. Normenut, M. D.

6 28, 1922 (Address) 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	June 28 1922
20 UNDERTAKER	ADDRESS
Ehrenwerth Son	Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65500 | 179 D 65500

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Ajax ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Sawyer

(a) RESIDENCE. No. 718 Ajax ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonora Chase Sawyer

6 DATE OF BIRTH (month, day, and year) March 4-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Leonora Chase Sawyer (Address) 718 Ajax St

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1921, to June 26, 1922; that I last saw him alive on June 25, 1922, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Clyde Burns, M. D.

, 19 (Address) 1218 Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 29 1922

20 UNDERTAKER Mrs J. G. Locks ADDRESS 1302 Jefferson St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65501

D 65501

CERTIFICATE OF DEATH.

123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 90 WARD)

2-FULL NAME Harry Beatty

(a) RESIDENCE NO. 111 W. Hilton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. White

4 COLOR OR RACE:

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Beatty

6 DATE OF BIRTH (month, day, and year) Mar 31 1870

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) P. R. R. 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER James Beatty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Susie Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Margt A. Beatty 911 N. Hilton St

15 Filed JUN 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1922 to June 26, 1922

that I last saw h alive on June 26, 1922

and that death occurred, on the date stated above, at 6 10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis - Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 6/16/22

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. W. Downey, M. D.

, 19 (Address) St. Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 29 1922

20 UNDERTAKER: E. A. Windsor — ADDRESS: 501 E 22nd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident: Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gall stones.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65502 | 13D 65502

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Duncan's Lane Rasp 36 St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Daniel J. Galombowski

(Residence in Baltimore: No. Duncans Lane Rasp St.; yrs. ..... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. June (Month) 13 (Day) 1922 (Year)

7-AGE. ..... yrs. ..... mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Frank Galombowski

11-BIRTHPLACE OF FATHER, (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Rose Rykowska

13-BIRTHPLACE OF MOTHER, (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Galombowski

(Address) Lemmon Lane

15- Filed JUN 28 1922 ROBERT R. KRAUTER, Vital Records Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Lesion
(Convulsion)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Not determined)
(Secondary) probably Pneumonia Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Pollitt M. D.
(Coroner.)
6 28 1922 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, June 29, 1922

20-UNDERTAKER, M. F. Sadowski. ADDRESS 703 S. Ann St.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65503

CERTIFICATE OF DEATH.

90

D 65503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 442 S. Robinson ST., 1 WARD)

2-FULL NAME Elizabeth Hagey

(a) RESIDENCE NO. 442 S. Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baltzer Hagey

6 DATE OF BIRTH (month, day, and year) March 6 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	3	21	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) housewife

(c) Name of employer —

9 BIRTHPLACE (city or town) Hamburg (State or country) Germany not known

PARENTS

10 NAME OF FATHER Baltzer Stauch

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Baltzer Hagey (Address) 442 S. Robinson St.

15 FILED JUN 28 1922 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from about 1918, to June 27, 1922, that I last saw h[illegible] alive on June 26, 1922, and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

asphyxia

cardiac dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy

mitral insufficiency (duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. W. Wright M. D.

6/28 1922 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL June 30 1922

20 UNDERTAKER Funkler & Finkler — ADDRESS 1739 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 65504

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Little Sisters of Poor aged Home ST.: 10 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bannerman

(Residence in Baltimore: No. Home for Aged Little Sisters of Poor ST.: Valley & Dunbar 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, July (Month) 4th (Day), 1839 (Year)

7-AGE, 82 yrs. 11 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bavaria

PARENTS.

10-NAME OF FATHER, Michael Bannerman

11-BIRTHPLACE OF FATHER (State or Country), Bavaria

12-MAIDEN NAME OF MOTHER Mary Kingross

13-BIRTHPLACE OF MOTHER (State or Country), Bavaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sister Josephine

(Address)..... Valley & Dunbar Sts

15-

Filed....., 191.....

Robert P. Harrison,

Registrar.

JUN 28 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. Sit Cotter M. D.
(Coroner.)

June 27, 1922 (Address) 508 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence:.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, June 30 19...

20-UNDERTAKER Will Cook ADDRESS 508 E. Fayette

D 65505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65505

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital, St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Loos.

(Residence in Baltimore: No. 18 N. Milton Avenue. St.; yrs Life mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, Divorced. (Write the word.): Married.

6-DATE OF BIRTH: July 29, 1893
(Month) (Day) (Year)

7-AGE: 28 yrs. 10 mos. 27 ds.
If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Agent
(b) General nature of industry, business, or establishment in which employed (or employer): Insurance

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Henry Loos.

11-BIRTHPLACE OF FATHER, (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Mary L. Coe.

13-BIRTHPLACE OF MOTHER, (State or Country): Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Henry Loos.
(Informant)
(Address) 4503 Weitzel Ave.

15-
JUN 28 1922 Robert P. Harrison,
192.....
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 26, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Duration ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

Duration ....yrs....mos....ds.

(Signed) Wm. J. Daly, M. D.
(Coroner.)

June 28 192.. (Address) 16 S. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery
DATE OF BURIAL: June 29, 22

20-UNDERTAKER: Wm Cook
ADDRESS: 502 E. North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Passey)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65506 D 65506

CERTIFICATE OF DEATH.

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Druid Hill Ave ST.: 14 WARD)

2-FULL NAME Ida Mary Passey

(a) RESIDENCE. NO. 2124 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12-1866

7 AGE 55 Years | 9 Months | 15 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Theodore Hand

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Moore

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Hattie M. Johnson
(Address) 2124 Druid Hill Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19 1922 to June 27, 1922.

that I last saw her alive on June 27, 1922.

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy 7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Shelley, M. D.

(Address) 1200 Druid Hill Ave 6/28/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peter's Cemetery

DATE OF BURIAL: 6-29 1922

20 UNDERTAKER: George H. Holland

ADDRESS: 1631 Orleans Ave

JUN 28 1922

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65507

CERTIFICATE OF DEATH.

1729 D 65507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Hawthorn Road, St. Roland Park WARD) 27

2-FULL NAME Edwin B. Adt

(a) RESIDENCE NO. 206 Hawthorn Road, St. Roland Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Kennady

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinery Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer) 082

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John B. Adt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Raine

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Ella Adt

(Address) 206 Hawthorn Road

15 JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to June 27, 1922

that I last saw h alive on June 26, 1922

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis - Arteriosclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Fernando R. Nuñez M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6/29, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65508

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Alice Anna ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Rok

(Residence in Baltimore: No. 1916 Alice Anna St.; yrs. 2 mos. 24 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MATRON, HOSPITAL, OR INSTITUTION

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Single

6-DATE OF BIRTH, April (Month) 4 (Day) 1922 (Year)

7-AGE,	If LESS than 1 day,
yrs. 2 mos. 24 da.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Boley. Miss.

PARENTS.

10-NAME OF FATHER, Antoni Rok.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Angelia Pugle.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angelia Rok (Mother)

(Address) 1916 Alice Anna St.

15-

Filed JUN 29 1922 ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 26 1922, to June 28 1922; that I saw h[illegible] alive on June 27 1922, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 1 mos. — ds.

(Signed) John H. Rehberger M. D.

June 29, 1922 (Address) 1709 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, H. Sacred Heart Cem. DATE OF BURIAL, June 29, 1922

20-UNDERTAKER W. F. Sadowski ADDRESS 405 S. Ann

Spec.—1-10-21—M&T—1500 Bks.

Buroki

65509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65509

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No. 76 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Burski

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Stanislaus Buroki

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE: Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bayview Hospital Baltimore Md.

15 FILED JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922 to June 24 1922

that I last saw her alive on June 24 1922

and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. H. Smith M. D.

6/28/22 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Polish Nat. DATE OF BURIAL: June 29 1922

20 UNDERTAKER: M. F. Sadowski ADDRESS: 705 S. Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65510

CERTIFICATE OF DEATH.

31

D 65510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S.V.HOSP.#56,

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 22 WARD)

2-FULL NAME Thomas J. Smallwood

(a) RESIDENCE No. 12 W.Hughes St.Balto.Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of ~~XXXXXXX~~ Mrs.Thomas J.Smallwood

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Basket Maker 086

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records

(Address) Ft.McHenry, Md.

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922, to June 27, 1922,

that I last saw him alive on June 27, 1922,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis (active)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Aneurism

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? no

What test confirmed diagnosis? X-Ray & Clinical Exam.

(Signed) H.B.Burke SURGEON (R) M. D.

6/27/22 (Address) U.S.V.Hosp.#56,Ft.McHenry,Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery DATE OF BURIAL June 29 1922

20 UNDERTAKER J. Lennon & Bro. ADDRESS 427 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65511

CERTIFICATE OF DEATH.

129 D 65511

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 949 N. Bond St. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. H. Schiminger

(a) RESIDENCE NO. 949 N. Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. -- ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imprtant. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: The late Victoria Schiminger

6 DATE OF BIRTH (month, day, and year): July-29-1878

7 AGE — Years: 43 Months: 11 Days: If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retail dealer in Ice, coal & wood

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Schiminger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Engelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Mary Schiminger (Address) 949 N. Bond St

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June-29-1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to June 29, 1922, that I last saw h— alive on June 28, 1922, and that death occurred, on the date stated above, at 3 A. M. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 6 mos 9 ds.

CONTRIBUTORY (Secondary): Cerebral Coma

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Kelly, M. D.

June 29, 1922 (Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: July 1-1922

20 UNDERTAKER: Henry Strauch Son

ADDRESS: 1301 E Eager

Spec.—1-10-21—M&T—1500 Bks.

D 65512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65512

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 820 Harford Ave. ST., (Ward) 10

2-FULL NAME Bridget. Curley

(a) RESIDENCE NO. 820 Harford Ave. ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Thomas. F. Curley

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	About 69	----	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Gahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Miss Margaret. A. Curley

(Address) 820 Harford Ave.

15 JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-28-1922

17 I HEREBY CERTIFY, That I attended deceased from 6/2, 1922, to 6/28, 1922, that I last saw h[er] alive on 6/28, 1922, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility - arteriosclerosis

Diabetes-mellitus

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Bernard Wiss, M. D.

July 1922 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: July 1 19 192

20 UNDERTAKER: Henry Hosek Son

ADDRESS 1301 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65513 101-101 D 65513

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 Bank ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luther Despeaux

(Residence in Baltimore: No. 2012 Bank St.; 1 yrs., 6 mos. 20 ds.)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 9 (Day), 1920 (Year)

7-AGE, 1 yrs. 6 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Adam Despeaux

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Laura Hoff

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. A. Despeaux

(Address) 2012 Bank St.

15-

Filed JUN. 29 1922 191.....

ROBERT B. KRAUTER, Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 25 1922, to June 28 1922, that I saw h[illegible] alive on June 28 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

.....

.....Pneumonia Lobar.....

..... (Duration).....yrs.....mos.....5.....ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

..... (Duration).....yrs.....mos.....1.....ds.

(Signed) A. L. Tumbleson M. D.

June 29, 1922 (Address) 2013 Bank St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. 1st German

DATE OF BURIAL, June 30 1922

20-UNDERTAKER Peter Nicolaus

ADDRESS, 5060 Eastern

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65514

CERTIFICATE OF DEATH.

113 D 65514

D 65514
1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 405 S Castel ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rozali Devlin

(a) RESIDENCE. No. 405 S Castel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Devlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rozali Jarecki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mr. William Devlin
(Address) 405 S Castel

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922 to June 28, 1922, that I last saw h[illegible] alive on June 28 1922, and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H E Tumbleson, M. D.

6/28 1922 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	June 29 1922

20 UNDERTAKER John M Weber ADDRESS 1803 Bank

Spec.—1-10-21—M&T—1500 Bks.

D 65515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-00

D 65515

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST.,

2-FULL NAME Joseph Dorsey

(a) RESIDENCE NO. 1522 Mount St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2/3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of WIFE Julia Dorsey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to June 27, 1922 that I last saw h[illegible]alive on June 27, 1922 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Peritonitis following obstruction of the intestine (small) due to adhesions

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Heart insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Yes Date of June 22 22.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) W. W. Finnegan, M. D.

6-28 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W Auburn — DATE OF BURIAL. June 30 1922

20 UNDERTAKER Sam'l R. Case Sons — ADDRESS 1400 McHenry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65516

CERTIFICATE OF DEATH.

74-001

74 D 65516

REGISTERED No. C.....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 Argyle Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Welsh

(Residence in Baltimore: No. 1040 Argyle Ave St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1867 (Year)

7-AGE, 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alma Welsh

(Address) 1040 Argyle

15- Filed JUN 29 1922, 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 6 (Month) – 26 (Day) –, 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23d 1922, to June 26th 1922, that I saw h[im] alive on June 26th 1922, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

..... Apoplexy .....

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jas. C. Carper M. D.

6-27-, 1922 (Address) 1062 Myrtle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, June 29 1922

20-UNDERTAKER Wm F Carson — ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

CERTIFICATE OF DEATH.

D 65517

REGISTERED NO. D 65517

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital, St. 2 WARD)

2-FULL NAME Mrs Anna Gordon.

(a) RESIDENCE NO. 2033 Bank St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arnold Gordon.

6 DATE OF BIRTH (month, day, and year) Nov. 17-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33. yrs.	7.	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mount Carmel Penn

PARENTS

10 NAME OF FATHER Tom Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Creager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records. (Address) Mercy Hospital

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from April 26 1922 to June 28 1922

that I last saw h alive on June 28, 1922

and that death occurred, on the date stated above, at 9.25 a m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis. (duration) only. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym. & Phys. findings

(Signed) H. J. Krauter M.D.

19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery DATE OF BURIAL July 1 1922

20 UNDERTAKER H. Vanderford Sons ADDRESS 1710 Flat St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D 65518 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 65518

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~Hospital~~ E. N. Carlton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Harry Lee

(Residence in Baltimore: No. E. N. Carlton St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. July (Month) 1 (Day) 1919 (Year)

7-AGE. 2 yrs. 11 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Harry Lee

11-BIRTHPLACE OF FATHER, (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Catherine Clark

13-BIRTHPLACE OF MOTHER, (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Boswell

(Address) 1054 Raborg St

15- JUN 29 1922 Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 28 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria ?

(Duration) ....yrs. ....mos. 1-2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Fenton M. D. (Coroner.)

June 27 192 2 (Address) 700 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, June 29 1922

20-UNDERTAKER, S. H. Brown & Son | ADDRESS 1 N Howard St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65519

CERTIFICATE OF DEATH.

D 65519

1-PLACE OF DEATH Municipal Hospitals 7th

REGISTERED NO. 98

CITY OF BALTIMORE: (No. ..... ST., 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Burrell

(a) RESIDENCE NO. 807 Pearl Alley ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Mrs. Reed 6/26/22

15 FILED JUN 29 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-26 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-27- 1922 to 6-26- 1922

that I last saw h[e] alive on 6-26-22 19 .....

and that death occurred, on the date stated above, at 10.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Clyde McNeil M. D.

Address Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: 19

20 UNDERTAKER: (Name) Belcher Hearse

ADDRESS: JUN 29 1922

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3-14

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65520 CERTIFICATE OF DEATH. 188-081 D 65520

1-PLACE OF DEATH Municipal Hospitals 5

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Miller

(a) RESIDENCE NO. East Fayette St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): D40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Mrs Lena

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-26-1922

17 I HEREBY CERTIFY, That I attended deceased from 6-20-1922 to 6-26-1922 that I last saw him alive on 6-25-1922 and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Mowell M. D.

6/28/1922 (Address) Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS JUN 1922

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imprtant. See instructions on back of certificates.

214

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65521

CERTIFICATE OF DEATH.

X 35 D 65521

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Municipal Hospital Va

CITY OF BALTIMORE (No. ..... ST. ..... WARD)

2-FULL NAME Jack Patterson

(a) RESIDENCE NO. 318 Frey St. Charlestown, W. Va —

(Usual place of abode) ST. ..... WARD .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-16

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: ~~White~~ Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE — Years: 23 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10 NAME OF FATHER: Wm Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va —

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va —

14 Informant (Address): Municipal Hospital Records

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-21, 1922, to 6-25, 1922, that I last saw him alive on 6-24, 1922, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

T. B. arthritis of left knee-9 left elbow joint. Witn mixed infection-

(duration) yrs. 4½ mos. ..... ds.

CONTRIBUTORY (Secondary) Sepsis

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of 4-3-22

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Brumbeck, M. D.

6-26, 1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER (Commissioner Health)

ADDRESS JUN 29 1922

MARGIN RESERVED FOR BINDING

P.N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65522

CERTIFICATE OF DEATH.

31 D 65522

1-PLACE OF DEATH Municipal Hospitals

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Curley

(a) RESIDENCE NO. 7 N. Howard ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or estshlishment in which employed (or employer): 02

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hosp. Records

15 JUN 29 1922 ROBERT R. KRAUTER, Registrar

FOR CITY Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26-1922

17

I HEREBY CERTIFY, That I attended deceased from 5-28-, 1922 to 6-26-, 1922

that I last saw him alive on 6-25, 1922

and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Interstitial

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Ingrowed Toenail

(duration) 5 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Mansell, M. D.

6/27, 1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER: Contractor Health. ADDRESS 1241 7 N. [illegible]

D 65523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Poplar Line E. near W. Md. R. R. Ward 11) 90

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Clarissa Armstrong

(Residence in Baltimore: No. 3003 Belmont Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Nov. 9, 1882
(Month) (Day) (Year)

7-AGE. 39 yrs. 7 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer). 837

9-BIRTHPLACE, (State or Country). Hazelton, Pa.

PARENTS.

10-NAME OF FATHER. John Knies

11-BIRTHPLACE OF FATHER. (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Catherine Steckert

13-BIRTHPLACE OF MOTHER. (State or Country). Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard D. Armstrong

(Address) 3003 Belmont Ave.

15- Filed JUN 29 1922 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 27, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

June 29 1922 (Address) 2302 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. June 30 1922

20-UNDERTAKER. Geo. W. Boyd & Son ADDRESS 2503 Ed monson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65524

CERTIFICATE OF DEATH.

74-001 D 65524

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 W. Pratt St. ST., 19 WARD)

2-FULL NAME Cecelia Pauline Kontner

(a) RESIDENCE NO. 1633 W. Pratt St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrud Kontner

6 DATE OF BIRTH (month, day, and year): Sept. 12th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: August Theinert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eleanore Maurer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry T. Kontner

(Address): 2016 Hollins St.

15 FILED JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1922, to June 27, 1922, that I last saw her alive on June 27, 1922, and that death occurred, on the date stated above, at 11.30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. V. O'neill, M. D.

6/27/22 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 29 1922
UNDERTAKER: Joseph B. Cook	ADDRESS: 1003 N. Balto St

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 65525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 65525

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Foreman

(a) RESIDENCE. No. 426 - 23rd st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wade Foreman

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Houston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M.T.H.

15 Filed JUN 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to June 28, 1922, that I last saw her alive on June 28, 1922, and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Palaglucci M. D.

6-28, 1922 (Address) Municipal Tbc. Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Liberty Cem	June 30 1922
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

~~D 65526~~ D 65526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1779

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Christs Institution Hospital ST., 17 (WARD) Enson St

2-FULL NAME Julia Agnes

(a) RESIDENCE No. 504 Hoffman St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Poland	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	60	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work 070

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Eleford Hack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hannah Heck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Anna Boston

(Address) 504 W Hoffman St

15 Filed JUN 29 1922 19 ... M T A. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1922 to June 27, 1922

that I last saw her alive on June 27, 1922

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright Disease

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease (duration) 1 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 546 Hoffman St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr G W Hammond, M. D.

6-27-1922 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mont Auburn — DATE OF BURIAL June 30 1922

20 UNDERTAKER John H Owens — ADDRESS 536 Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D 65527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE (No. Foot of Potomac St.: 1 WARD) — REGISTERED No. C 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. 11 St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Unknown

6-DATE OF BIRTH: Unknown (Month), 1 (Day), (Year)

7-AGE, About 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): 017

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) Eastern Dist

15- Filed June 28 1922 Robert P. Harrison, Registrar.

Burial Permit Issued

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21st (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo. B. Hutton M. D. (Coroner)

June 28 1922 (Address) Curtis Bay, Balto. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, , 19

20-UNDERTAKER ADDRESS

Department of Health, 1922

Spec.—1-10-21—M&T—1500 Bks.

D 65528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65528

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Morrow Hospital ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Hinson

(a) RESIDENCE NO. 1902 Poplar Grove ST., WARD Ocran, Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Alice Hinsen

6 DATE OF BIRTH (month, day, and year) Nov 18 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Fishing Ships

(c) Name of employer Bellows & Ogura

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Phillip Hinsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Jane Delf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Clara Sherman

(Address) 1902 Poplar Grove St Ocn

15 Filed ....., 19 ..... Registrar

N 29 1922

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1922, to 6/28, 1922, that I last saw him alive on 6/28, 1922, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis and Cardiac Insufficiency

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) General Anasarca

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) P. E. Delvalo, M. D.

, 19 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ocran Meth. Va	June 30 19 22

20 UNDERTAKER	ADDRESS
Wm J Tuckwell Sons	Norfolk Va

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65529

CERTIFICATE OF DEATH.

129 D 65529

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 Callender ST., 18 WARD)

2-FULL NAME Margaret A. Sheckells

(a) RESIDENCE NO. 116 Callender ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Merrick R. Sheckells

6 DATE OF BIRTH (month, day, and year) Nov 14 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER William Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md

12 MAIDEN NAME OF MOTHER Mary E. Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md

14 Informant Joseph M. Sheckells

(Address) 116 Callender

15 Filed ..... 19 ..... Registrar

JUN 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1922, to June 29 1922, that I last saw h.. alive on June 28 1922 and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Urine etc.

(Signed) Thos. Haystone, M. D.

(Address) 988 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mount Olivet Cemetery 1922

20 UNDERTAKER — ADDRESS

Fos Foerdans Son 2173 Pa Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65530

D 65530

CERTIFICATE OF DEATH.

58-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3615 Springdale Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Grove Smith

(a) RESIDENCE. NO. 3615 Springdale Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas a. Smith

6 DATE OF BIRTH (month, day, and year) Mar. 16. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Wm H. Grove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Margaret V. Chestnut

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Pauline V. Houston
(Address) 3401 Elgin Ave

15 Filed JUN 9 1922 19 Robt F. Harrison, Registrar
JUN 9 1922 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar 21, 1922, to June 28, 1922, that I last saw h[illegible] alive on June 28, 1922, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur R Schampert M. D.

6/29 1922 (Address) 2846 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem. Frederick Md	July 1 1922
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	1944 W. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65531 D 65531

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Johnson

(a) RESIDENCE. No. 28 S. Durham st. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ben Johnson

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Press Machine Oper.

(b) General nature of industry, business, or establishment in which employed (or employer) Can Factory 086

(c) Name of employer Southern Can Co.

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pennsylvania

PARENTS

10 NAME OF FATHER Chas. Von Bergen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 JUN 29 1922, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to June 27, 1922, that I last saw her alive on June 27, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous broncho-pneumonia

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Kenneth L. Babylasee, M. D.

6-28-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 1 1922
20 UNDERTAKER F. A. Kramer Son	ADDRESS 705 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65532

CERTIFICATE OF DEATH.

44 D 65532

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 Augusta ave St. 20 WARD)

2-FULL NAME Mrs. John Kennedy

(a) RESIDENCE. No. 134 Augusta ave St., WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 55 yrs. ..... mos. ..... ds.

X. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary V. Kennedy

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years: 62; Months: ; Days: ; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oyster Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer: State of Md

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Danial Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary V. Kennedy

(Address) 134 Augusta ave

15 Filed JUN 9 1922, 19..... Registrar

ROBERT J. CARRISON,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to June 27, 1922, that I last saw h in alive on June 26, 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) about 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Vomiting, vomiting, Lump in stomach

(Signed) Charles O'Donovan, M. D

June 29, 1922 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: June 30 1922

20 UNDERTAKER: D. A. Krauss & Son — ADDRESS: 709 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65533

CERTIFICATE OF DEATH.

148 D 65533

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Riverside Av ST.; 24 WARD)

2-FULL NAME Sarah L. Hutchins

(a) RESIDENCE. No. 1411 Riverside ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. T. Hutchins

6 DATE OF BIRTH (month, day, and year) Oct 9, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md.

PARENTS

10 NAME OF FATHER Henry C. Dorland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Burkhead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Jno Hutchins 1411 Riverside

15 Filed [illegible] 19 [illegible] Registrar

1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to June 28, 1922, that I last saw her alive on June 28, 1922, and that death occurred, on the date stated above, at 4 10 P. M.

The CAUSE OF DEATH* was as follows:

Confinement.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Edw Smith, M. D.

June 1922 (Address) 911 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Barstow Calvert Co. Md.	June 30 1922

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1460 Battery Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 29

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65534

CERTIFICATE OF DEATH.

D 65534

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 406 Henderson St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Emma Sinclair

(Residence in Baltimore: No. 406 Henderson St. St.; yrs. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: June 28, 1854 (Month) (Day) (Year)

7-AGE: 68 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country): Georgia

PARENTS.

10-NAME OF FATHER, ? Baines

11-BIRTHPLACE OF FATHER, (State or Country), U.S.A.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar Sinclair

(Address) 3414 Old York Rd.

15- Robert P. Harrison,

Filed ..... 192.....

Registrar.

2 9 1922 Deputy Health Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion of Abdomen
Rupture of Heart

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) John H. Sinclair M. D.
(Coroner.)

Dec 29 1922 (Address) 213 N. Calvert

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: June 30 1922

20-UNDERTAKER: Wm Cook — ADDRESS: K T & G Mc

Spec.—1-10-21—M&T—1500 Blks.

D 65535

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 - 001

D 65535

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 818 Leadenhall ST., 22 WARD)

2-FULL NAME David Coston

(a) RESIDENCE NO. 808 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Horace Coston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellen Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Horace Coston (Address) 808 Leadenhall St

15 Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1922, to June 27, 1922, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 9-30 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation by Dr. Stubbs

(Signed) A. P. Stubbs M. D.

19 (Address) 714 S Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 30 1922
20 UNDERTAKER	ADDRESS
John H. Toadvine	1422 Ursell St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. 6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65536

D 65536

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 W Lanvale St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Phelps Brooks.

(a) RESIDENCE: No. 529 W Lanvale St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Viola Brooks

6 DATE OF BIRTH (month, day, and year) Oct 1, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 086

(b) General nature of industry, business, or establishment in which employed (or employer) Housing Cor.

(c) Name of employer Self St Lanfair

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER John Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Mildred Murlay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co.

14 Informant Viola Brooks. (Address) 529 W Lanvale St.

15 Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to June 28, 1922, that I last saw h— alive on June 27, 1922, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation ?

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteri-Sclerosis ?

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William A. Wright, M. D.

June 28, 1922 (Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 1 1922
20 UNDERTAKER John A Toadvine	ADDRESS 142 W Fielder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65537

CERTIFICATE OF DEATH.

10

90 D 65537

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 719 Sterling St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Carrie (Brown) McNeil

(Residence in Baltimore: No. 719 Sterling St., (yrs. 4) mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Presser 186
(b) General nature of Industry, business, or establishment in which employed (or employer) Bonne Tailoring

9-BIRTHPLACE, (State or Country). South Carolina

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Kemp

(Address) 719 Sterling St.

15-

Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY, (Secondary) History of influenza during last winter

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Falkenau M. D. (Coroner.)

6-27 1922 (Address) 508 E. Fort Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery DATE OF BURIAL, June 30 1922

20-UNDERTAKER. Clement Hall ADDRESS 1914 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65538

D 65538

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 17 WARD)

2-FULL NAME Mary Banks

(a) RESIDENCE. NO. 526 Orchard St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clintown

6 DATE OF BIRTH (month, day, and year): Clinton, 1848

7 AGE: Years 74 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Clintown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Clintown

12 MAIDEN NAME OF MOTHER: Rebecca Baston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hospital Records

15 Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/28/22 19

17 I HEREBY CERTIFY, That I attended deceased from 5/28/22, 19, to 6/28/22, 19, that I last saw her alive on 6/28/22, 19, and that death occurred, on the date stated above, at 9:50 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. A. McKay M. D

, 19 (Address) Bayview Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MD Cemetery Co. DATE OF BURIAL: June 30 1922

20 UNDERTAKER: Samuel Hemsley ADDRESS: 528 Eddie

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65539

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S. Gilmor ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Flick

(a) RESIDENCE. No. 318 S Gilmor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Galvin Flick

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Product 866

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER William N Flick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary A. Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Geo Gillis (Address) 318 S Gilmor St

15 Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922, to June 27, 1922, that I last saw h/ alive on June 27, 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) J Chas Tanton, M. D.

6/30/1922 (Address) 888 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 30 1922
20 UNDERTAKER John J Cowan & Son	ADDRESS 501 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65540 D 65540

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Raborg ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garfield Lewis

(a) RESIDENCE. No. 610 Raborg ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Doretha Lewis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER George Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Willie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Doretha Lewis

(Address) 610 Raborg St

15 Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to June 27, 1922, that I last saw h.... alive on June 27, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

June 27 1922 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Antrim	June 30 1922
20 UNDERTAKER	ADDRESS 117 W. Fayette St.
Brannon Funeral Home	

Spec.—1-10-21—M&T—1500 Bks.

D 65541

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65541

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 330 S Smallwood ST., 20 WARD)

2-FULL NAME Alvordia Ingallis

(a) RESIDENCE NO. 330 S Smallwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D Ingallis

6 DATE OF BIRTH (month, day, and year): May 7-1847

7 AGE: 75 Years Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Robert Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Catherine Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Catherine Schultz

(Address) 330 S Smallwood St

15 Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922, to June 29, 1922,

that I last saw h[illegible] alive on June 29, 1922, at 1.15 P m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Endocarditis

(duration) yrs 1 mos ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) Robert C Tyler, M. D.

June 29, 1922 (Address) 2151 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 1 1922

20 UNDERTAKER: Wm Cook Son & Stanfield — ADDRESS

Spec.—5-19-13—M. & T.—500 Bks.

D 65542

HEALTH DEPARTMENT—CITY OF BALTIMORE

161 001 D 65542

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3215 Abell Av ST.; 12 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Catherine Downing

(Residence in Baltimore: No. 3215 Abell Av St.; ....yrs., mos. 2 hs ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, June 29, 1922 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos....ds.	12 hrs. ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—
(b) General nature of industry, business, or establishment in which employed (or employer).....—

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Norman P Downing

11-BIRTHPLACE OF FATHER (State or Country), Kent Co, Md

12-MAIDEN NAME OF MOTHER Katherine Downing

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman P. Downing

(Address) 3215 Abell Av

15- FILED JUN 30 1922 ROBERT R. KRAUTER, 191.....
Registrar.
Burial Permit ONLY.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 29 1922, to June 29 1922, that I saw h— alive on June 29 1922, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth
ama 6 1/2 months

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) G. W. Bishop M. D.

June 30., 1922 (Address) 321 Sheridan Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 hs ds. In the State ....yrs. ....mos. 12 hs ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same.

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, June 30., 1922

20-UNDERTAKER Lowe Cook

ADDRESS 502 E Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kelleher. ✓

D 65543

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 65543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor, 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Kelleher.

(a) RESIDENCE. No. Preston & Valley Sts. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Kelleher.

6 DATE OF BIRTH (month, day, and year) March 16-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Haggerty

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Kate —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor, (Address) Preston & Valley Sts

15 Filed JUN 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from ..... 19.. to record ..... 19..

that I last saw h er alive on June 29 1922

and that death occurred, on the date stated above, at 1. P. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Warner, M. D.

June 29 1922 (Address) 1103 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	July 1 1922

20 UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

65544

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C D 65544

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 5224 main St Arlington)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella Stansbury

(Residence in Baltimore: No. 5224 main St Arlington yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F

4-COLOR OR RACE White

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word) Widow

6-DATE OF BIRTH July 27 (Month) 1840 (Day) (Year)

7-AGE 82 yrs. 11 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Inmate
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto md

PARENTS

10-NAME OF FATHER Philip Hare

11-BIRTHPLACE OF FATHER (State or country) md

12-MAIDEN NAME OF MOTHER Margaret Bobbitz

13-BIRTHPLACE OF MOTHER (State or country) md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Stansbury

(Address) 5224 main St

15-

Filed JUN 30 1922 ROBERT R. KNAUER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 6 (Month) 29 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July, 1921, to, June 29 1922

that I saw h[illegible] alive on June 29 1922

and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 9 yrs. mos. ds.

Contributory (SECONDARY) Mitral regurgitation
Arterio-sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) Henry Russell M. D.

6/29, 1922 [Address] 3902 Greenland

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Druid Ridge

DATE OF BURIAL July 1, 1922

20-UNDERTAKER Chenowith Son

ADDRESS Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 65545 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65545

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 N Payson ST.: 16 WARD)

REGISTERED NO. 86-01

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ramon Leo Connelly

(a) RESIDENCE. NO. 902 N. Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 13-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John J. Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elsie D. Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John J. Connelly
(Address) 902 N Payson

15 Filed JUN 30 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to June 29, 1922 that I last saw h[illegible] alive on June 29, 1922 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Simplex)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. Kelly Herrmann, M. D.

6/29 1922 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 1 1922
20 UNDERTAKER	ADDRESS
Martin Fankard	1827 W North

D 65546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65546

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Devil's Bucket Foot of Haubert St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Bantum, (C). 31 --- 6 -----.

(Residence in Baltimore: No. 1404 McElderry St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. December 25th, 1890. 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
31 yrs. 6 mos. ----- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer Street
(b) General nature of industry, business, or establishment in which employed (or employer): Cleaning Dept.

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Isaiah Bantum. (C).

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER, Sarah Reed. (C).

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Bantum. (C). (wife).

(Address) 1404 McElderry St.

15-Filed JUN 30 1922, 192. ROBERT R. KNAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Missing June 25th, 1922. Body found June 29th, 1922., 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

June 30 192 2. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	June 30 1922

20-UNDERTAKER, Mrs Robert-A Elliott ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65547

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1526 E. Fairmount St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Walker

(Residence in Baltimore: No. 1526 E Fairmount Ave St.; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the Word.)
Male	Negro	Married

6-DATE OF BIRTH. unknown 1838
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
41 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Junk Dealer,
(b) General nature of industry, business, or establishment in which employed (or employer): D+S

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. T. Redding

(Address) 1446 E. Fairmount Ave.

15- Robert P. Harrison,

Filed..... 192..... Registrar.

JUN 30 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said M.D. Murray (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) yrs. mos. ds.

(Signed) J. S. T. Dolan M. D.
(Coroner.)

6/30 192 2. (Address) 408 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Hill Cemetery DATE OF BURIAL, July 1 192 2

20-UNDERTAKER Chas. R. Jenson ADDRESS 416 N. Carrollton Av.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65548

CERTIFICATE OF DEATH.

162

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Baby Allers

(a) RESIDENCE NO. 830 Hollins ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 26, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Harry Allers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Wiemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. Records. (Address)

15 Filed JUN 30 1922, 19 ..... Registrar

Robert P. Harrison, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1922 to June 28, 1922, that I last saw him alive on June 28, 1922 and that death occurred, on the date stated above, at 2.18 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis (Congenital)

(duration) ✓ yrs. ✓ mos. 2 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? ✓

(Signed) H. Cathcart, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUN 30 1922, 19

20 UNDERTAKER Commissioner of Health, (Address) [illegible] E. WOODALL

ADDRESS

Burial Permit Clerk

JUN 30 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65549

CERTIFICATE OF DEATH.

161 - D 65549

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 East St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cresswell

(a) RESIDENCE. No. 423 East St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby

6 DATE OF BIRTH (month, day, and year): 6-26-1922

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or 0 min.
(	0	0	0,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Basil Cresswell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Daisy Kelby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Johns Hopkins Hospital Records JOHNS

15 Filed , 19 Robert F. [illegible] Registrar

Burial Permit Clerk.

JUN 30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to June 26, 1922, that I last saw her alive on June 26, 1922, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

Atelectasis of Lung

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Cattrall M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: JUN 30 1922

20 UNDERTAKER

ADDRESS

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

216

Spec.—1-10-21—M&T—1500 Blks.

D 65550

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65550

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 27 WARD)

2-FULL NAME Mr Harry Kinlein

(a) RESIDENCE No. 4600 Eldorado Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Fannie Kinlein

6 DATE OF BIRTH (month, day, and year) Jan. 27, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer - 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Kinlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dorothy Beltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mercy Hospital Records (Address)

15 JUN 30 1922, 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to June 30, 1922, that I last saw him alive on June 30, 1922, and that death occurred, on the date stated above, at 4 20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of June 30, 1922

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs Symptoms

(Signed) John J Erwin, M.D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL July 5 1922

20 UNDERTAKER Henry Hoech Son — ADDRESS 1301 E Eager St

JUN 30 1922

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65551

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3152 Cedar Ave ST., 13 WARD)

2-FULL NAME Thomas Howard Reid

(a) RESIDENCE NO. 3152 Cedar Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella M. Reid

6 DATE OF BIRTH (month, day, and year) Dec. 29-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	42	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millworker 646

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mills

(c) Name of employer Mt. Vernon Mills

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Boyd Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann J. England

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Ella M. Reid

(Address) 3152 Cedar Ave

15 JUN 30 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to June 27, 1922, that I last saw him alive on Jan 27, 1922, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

(Phthisis)

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr A C Jamison, M. D.

19 (Address) 4 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 1 1922

20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Hall Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65552

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 31

D 65552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.VETERANS' HOSP.#56, REGISTERED NO.....

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 2E WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN BARBER

(a) RESIDENCE No. 233 Richwood Ave. Morgantown, West Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of ~~XXXXXXXX~~ Mrs.John Barber

6 DATE OF BIRTH (month, day, and year) ----

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tin Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant HOSPITAL RECORDS,

(Address) Ft.McHenry,Md.

15 Filed JUN 30 1922, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1922, to June 30, 1922, that I last saw him alive on June 30, 1922, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary tuberculosis,
far advanced and active

- (duration) - yrs. - mos ds.

CONTRIBUTORY (Secondary) ---

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? no

What test confirmed diagnosis? Clinic.& Lab.Reports

(Signed) H.D.ROSE, (SURGEON(R)), M. D.

6/30 1922 (Address) U.S.V.HOSP.#56, Ft.McHenry,Md.

OK. WMD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgantown W. Va. DATE OF BURIAL June 30 1922

20 UNDERTAKER L Leuson Bur ADDRESS 1127 E Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 30 1922

Spec.—1-10-21—M&T—1500 Bks.

Corone given details of case. & ordered that a Coroner's Certificate be issued

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65553

185 D 65553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., N WARD)

2-FULL NAME Minnie Young.

(a) RESIDENCE NO. 2200 Ave - 122nd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Young

6 DATE OF BIRTH (month, day, and year) Mar 22 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. ? ?

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Fleischmann

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Sifer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

JUN 30 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to June 30, 1922, that I last saw her alive on June 29, 1922, and that death occurred, on the date stated above, at 6.55 a.m.

The CAUSE OF DEATH* was as follows:

Compound - supra-condyle fracture of right femur.

(duration) ? yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia Senility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical findings

(Signed) F. W. Brumbeck, M. D.

6-30 1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethlehem Cem. DATE OF BURIAL July 3 1922

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eutaw St.

N. B.—WHITE PAPER, WITH UNSPARING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Fracture due to fall. History from undertaker. Pty. did not know cause of

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

M. Adam Stapp

CORONER FOR BALTIMORE CITY-EASTERN DISTRICT.

M. D.

CORONER FOR BALTIMORE CITY-EASTERN DISTRICT.

D 65554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65554

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 819 W. Franklin St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sarah Webster

(Residence in Baltimore: No. 819 W. Franklin St. St. 1 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Sgle

6-DATE OF BIRTH. June (Month) 9 (Day) 1920 (Year)

7-AGE. 1 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(h) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. Charlie Webster

11-BIRTHPLACE OF FATHER, (State or Country). Union Md

12-MAIDEN NAME OF MOTHER. Sadonia Blackwell

13-BIRTHPLACE OF MOTHER, (State or Country). Northumberland Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Sadonia Webster

(Address). 819 W. Franklin st

15-

Filed ..... 192 ..... Registrar.

JUL 1 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 29 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ... his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) Heat & food!

(Duration) ... yrs. ... mos. 12 ds.

(Signed) W. B. Freeman (Coroner.) M. D.

6-29 1922 (Address) 117 W. Saratoga st

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL 7/1 1922

20-UNDERTAKER. Jas. Wm. Skinner ADDRESS 625 E. Lead. st

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

8—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SPACE RESERVED FOR RESIDENCE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65555

CERTIFICATE OF DEATH.

161 001 D 65555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nelson

(a) RESIDENCE. No. 1811 W. Lanvale. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. / ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29, 1922

7 AGE	Years	Months	Days	If LESS than 1 day	hrs. or min.
					14½

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Raymond Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Esther Whitehead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Mrs. Esther Whitehead
(Address) 1811 W. Lanvale St

15 Filed JUL 1 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1922 to June 30, 1922 that I last saw him alive on June 30 1922 and that death occurred, on the date stated above, at 3-30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity -

(duration) 14½ hours ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1811 W. Lanvale St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Stanley W. Mathews, M. D.

, 19 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Interred Loudon Park Cemetery	July 1 1922

20 UNDERTAKER George J. Smith

ADDRESS 1000 E. Fayette St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 65556 HEALTH DEPARTMENT—CITY OF BALTIMORE, D 65556

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 448 Augusta Ave ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Kornmann

(a) RESIDENCE. No. 448 Augusta Ave ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Rosa Kornmann

6 DATE OF BIRTH (month, day, and year): Dec 6 - 1864

7 AGE: Years 57 Months 6. Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman Oil

(b) General nature of industry, business, or establishment in which employed (or employer): Wm Lederer

(c) Name of employer: Wm Lederer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Kornmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Rosa Kornmann 448 Augusta Ave

15 Filed JUL 7 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to June 29, 1922, that I last saw him alive on June 29, 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Hepatic Flexure Colon

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Heart Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 12/22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry J Stahr, M. D.

6/29 1922 (Address) 73 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 3 1922

20 UNDERTAKER: George F Smith — ADDRESS 1900 N Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65557

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2539, N. 5th St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gillian Randell

(Residence in Baltimore: No. 2539 - N. 5th. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, March 16 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Frank Randell

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Pearl Miller

13-BIRTHPLACE OF MOTHER (State or Country). Del

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A Farrell

(Address) 2319 Division St

15-

Filed JUL 1 1922 191 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, find that said deceased came to h.. death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.
(Coroner.)

July 1, 1922 (Address) 962 Robert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, July 1922

20-UNDERTAKER mrs R. a Elliott

ADDRESS 1421 Fotshland ave

Remarks

Gastro intestinal indigestion Bad feeding

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65558

CERTIFICATE OF DEATH.

D 65558

1-PLACE OF DEATH

CITY OF BALTIMORE ..... ST. ..... (WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME .....

(Residence in Baltimore: No. ..... St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED,~~ ~~WIDOWED,~~ ~~OR DIVORCED,~~ (Write the word.)

6-DATE OF BIRTH, Dec 25th 1911
(Month) (Day) (Year)

7-AGE, 10 yrs. 6 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0

9-BIRTHPLACE. (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Wm Yingling

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Yingling

(Address) 21 Hooper Ave

15-

Filed, JUL 1 - 1922 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and thereon and from the evidence obtained by myself and Inquest, find that said deceased came to death on the date stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Drowning accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

June 30 1922 (Address) 21 22 Roberts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Rockdale Town Md DATE OF BURIAL, July 2 1922

20-UNDERTAKER Chenoweth & Son ADDRESS Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65559

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3709 Foster Ave. ST., N WARD)

2-FULL NAME Nicholas Krepp.

(a) RESIDENCE NO. 3709 Foster Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Krepp.

6 DATE OF BIRTH (month, day, and year) Sept. 17-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer U. S. Custom house.

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER John Krepp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Emma Krepp. (Address) 3709 Foster Ave.

15 JUL 7-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 19 22

17 I HEREBY CERTIFY, That I attended deceased from 1/14 22, 19, to 6-29 22, 19.

that I last saw h alive on 6-29 22, 19,

and that death occurred, on the date stated above, at 5.46 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Wasting.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D W Hausman, M. D.

6-30 19 22 (Address) 2914 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL July 3 1922

20 UNDERTAKER Lilly & Zeiler. ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65560

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-08 D 65560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2910 Hudson St. ST., 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Crispens

(a) RESIDENCE NO. 2910 Hudson St. ST., 1st WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of David Crispens

6 DATE OF BIRTH (month, day, and year) May 27-1867.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home. 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Friese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Ger.

14 Informant David Crispens

(Address) 2910 Hudson St.

15 Filed JUL 1- 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to June 28, 1922, that I last saw ... alive on June 28, 1922, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 3? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine

(Signed) Frank A. Hantz, M. D.

June 30, 1922 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL July 1st 22

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65561

CERTIFICATE OF DEATH.

D 65561

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1030 W Lexington St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Smith G. Taylor

(Residence in Baltimore: No. 1031 W Lexington St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. April 8 1854 (Month) (Day) (Year)

7-AGE. 68 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Minister + Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER. Matthew Taylor

11-BIRTHPLACE OF FATHER, (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Sarah Davis

13-BIRTHPLACE OF MOTHER, (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Taylor

(Address) 1030 W Lexington St

15-

Filed JUL 1 - 1922 19.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Inflamatory Rheumatism

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis, Bronchitis

(Duration) yrs. 6 mos. ds.

(Signed) James H. Preston M. D. (Coroner.)

July 1 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Statesville N.C. DATE OF BURIAL. July 1, 1922

20-UNDERTAKER. Brown & Freeland & Schroder ADDRESS 114 W

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65562

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.:) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. John Goeller

(a) RESIDENCE. No. 3051 W. North Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 26, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
26	26	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Geo. Goeller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Schreiber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hospital Records

15 Filed JUL 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 1, 1922.

that I last saw him alive on July 1, 1922.

and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Ileus Appendicitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 3051 W. North Ave

Did an operation precede death? Yes Date of June 26, 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Vincent Joska, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a.a.B.

DATE OF BURIAL: 7-3 1922

20 UNDERTAKER: E & B Hasle

ADDRESS: 1152 E. Ost

N. B.—MAKE RECORD, WITH CAPABLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65563

CERTIFICATE OF DEATH.

113

D 65563

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1240 Glyndon Ave ST.; 7 WARD)

2-FULL NAME Doris M. Reuss

(a) RESIDENCE. No. 1240 Glyndon Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Elmer Reuss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary C Kimball

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bath Md.

14 Informant Elmer Reuss
(Address) 1240 Glyndon

15 Filed JUL 1 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to June 29, 1922, that I last saw h alive on June 29, 1922, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Campbell M. D.

June 30 1922 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL July 1 1922

20 UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65564 21 D 65564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospitals

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME William W. Christopher Jr.

(a) RESIDENCE No. 1258 Broadway ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Christopher

6 DATE OF BIRTH (month, day, and year): March 14-1880

7 AGE: Years 4 2 — Months 3 — Days 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Wm Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Laura Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Hosp. Roads

15 Filed JUL 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/30/1922

17 I HEREBY CERTIFY, That I attended deceased from 6/30, 1922, to 6/30, 1922, that I last saw h[illegible]ive on 6/30, 1922, and that death occurred, on the date stated above, at 5.05 p m.

The CAUSE OF DEATH* was as follows:

Facial erysipelas

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Clyde McNeil M. D.

1922 (Address) City Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 7/3 1922

20 UNDERTAKER: Chas F. Evans & Son — ADDRESS: 1111 W. Baltimore

INFORMATION, WITH CARBONS FOR THIS DEPARTMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D 65565

CERTIFICATE OF DEATH.

D 65565

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Fait ave. ST., [illegible] WARD)

2-FULL NAME Edward F. R. Hugel

(a) RESIDENCE No. 3210 Fait ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 29-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER F.A. Hugel

11 BIRTHPLACE OF FATHER (city or town) Balto., (State or country) Md.

12 MAIDEN NAME OF MOTHER Agnes S. Ompetda

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Agnes S. Hugel (Address) 3210 Fait Ave

15 Filed JUL 1 - 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to June 30, 1922

that I last saw him alive on June 30, 1922

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Dilated heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? — Clinical

(Signed) M. J. McAvoy, M. D.

July 1, 1922 (Address) 839 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL July 3 1922

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Lage

I. B. Write plainly, with pen and ink. Do not use pencil. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65566

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 E 31st ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Johnson

(a) RESIDENCE. NO. 204 E 31st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Late Peter Johnson

6 DATE OF BIRTH (month, day, and year): July 3, 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: Mr. Olsen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Andrew F. Johnson

(Address): Mullers Lane

15 Filed JUL 1 - 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1918, to June 30, 1922; that I last saw h[er] alive on June 30, 1922; and that death occurred, on the date stated above, at 11:[illegible] m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Arterio-sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Cullen, M. D.

19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem. DATE OF BURIAL: July 3, 1922

20 UNDERTAKER: Margaret D. Flynn ADDRESS: 1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65567

CERTIFICATE OF DEATH.

REGISTERED NO. 102

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Pennsylvania Ave. WARD) 15

2-FULL NAME Bridget Robinson

(a) RESIDENCE. No. 2460 Pennsylvania WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. 11-30

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: George W Robinson

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 42 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Philip Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: George Robinson (Address) 2460 Pennsylvania Ave

15 Filed JUL 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1922 to July 1, 1922.

that I last saw her alive on June 30, 1922.

and that death occurred, on the date stated above, at 3:40 a.m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): acute intoxication

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 30/22

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Mitchell, M. D.

July 1, 1922 (Address) 1903 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnstown Pa

DATE OF BURIAL: July 9 1922

20 UNDERTAKER: Martin Fahey & Sons

ADDRESS: 421 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 65568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65568

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Dolphin St., Ward 11)

2-FULL NAME Baum St. Jones

(a) RESIDENCE NO. 1217 Dolphin St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15th 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1217 Baltimore, Md

PARENTS

10 NAME OF FATHER Baum St. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Scruggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Jones

(Address) 1217 Dolphin St.

15 Filed JUL 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/1922

17 I HEREBY CERTIFY, That I attended deceased from 6/26/1922 to 6/30/1922

that I last saw him alive on 6/30/1922

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 1217 Dolphin St. 7/6, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Gay Cemetery — DATE OF BURIAL July 1 1922

20 UNDERTAKER Jno. M. Johnson — ADDRESS 1284 Eutaw St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M/4T—1500 Blks.

D 65569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65569

161-001 11875

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Womans Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Winans Hutton

(a) RESIDENCE NO. 2000 Woodlawn Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 30, 1922

7 AGE: Years | Months | Days | If LESS than 1 day, 7 hrs. 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Reginald Winans Hutton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Newport R.I.

12 MAIDEN NAME OF MOTHER: Isabel Catherine Donnelly Winans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boston Mass

14 Informant (Address): Reginald Winans Hutton Woodlawn Ave

15 JUL 19 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922, to July 1, 1922, that I last saw him alive on June 30, 1922, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth - 5½ months baby

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Norman E. Tannenbaum M. D.

(Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 7-1 1922

20 UNDERTAKER: Forrest Eustis Sons Co

ADDRESS: 1711 Eutaw Place

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65570

HEALTH DEPARTMENT—CITY OF BALTIMORE

65570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Woodland ST.: 26 WARD)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Agnes Glenn

(a) RESIDENCE. NO. 1 Woodland ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-27-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alex Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Agnes Glenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mrs Glenn
(Address) 1 Woodland Ave

15 JUL 1- 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-22 19

17 I HEREBY CERTIFY, That I attended deceased from 6-29, 19 22, to 7-1-22, 19, that I last saw h[e] alive on 6-30-22, 19, and that death occurred, on the date stated above, at 9:29 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. — mos. — 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms findings

(Signed) W. A. Knell M. D.

7/1, 19 22 (Address) Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hall of Redemption	July 1 1922
20 UNDERTAKER	ADDRESS
John Grabliauckas	420 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1 10-21—M&T—1500 Bks.

65571

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65571

CERTIFICATE OF DEATH.

90 D 65571

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Kelly

(a) RESIDENCE NO. 207 N. Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Kelly

6 DATE OF BIRTH (month, day, and year) Jun 9 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Krontz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Conflonn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Edward J. Kelly

(Address) 207 N. Curley St.

15 Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922 to June 29, 1922

that I last saw her alive on June 29, 1922

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? S. & P. S. & autopsy.

(Signed) John C. Schenuich M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 7/3 1922

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65572.

D 65572

CERTIFICATE OF DEATH.

X 43

D 65572

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Howard A. Kelly Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph Hallier.

(a) RESIDENCE. NO. 4626 N. 2nd Ave ST.: WARD. Birmingham, Ala.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Welfare Work.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) South Wales

PARENTS

10 NAME OF FATHER William Hallier

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Wales

12 MAIDEN NAME OF MOTHER Catherin Jenkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Wales

14 Informant Elizabeth Broadhead

(Address) 4626 N 2nd ave Birmingham ala

15 Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to June 30, 1922, that I last saw h... alive on June 30, 1922, and that death occurred, on the date stated above, at 12 40 P. m.

The CAUSE OF DEATH* was as follows:

Squamous cell carcinoma of the tongue.

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Robert E. F... M. D.

. 19 (Address) 1418 Eton Place, City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Birmingham Ala — DATE OF BURIAL July 1 1922

20 UNDERTAKER Chas. J. Black — ADDRESS 742 S. North ave

22 6 2 7 0

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

John Hallier

Spec.—6-9-19—H. P. Co.—1000 Bks.

65573

D 65573

HEALTH DEPARTMENT—CITY OF BALTIMORE

65573

H S D 65573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital (St.:) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. McGrath

(a) RESIDENCE. No. 1714 E Madison St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rena Mc Grath

6 DATE OF BIRTH (month, day, and year): Sept 23rd 1858

7 AGE — Years: 63 — Months: 9 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Deputy Jail Warden

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fruitland Maryland

PARENTS

10 NAME OF FATHER: Josiah Mc Grath

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eleanor E Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Maryland

14 Informant: J. H. Mc Grath (Address): 1714 E Madison

15 Filed JUL 2 - 1922 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28th 1922 to June 30th 1922, that I last saw h[illegible] alive on June 30th 1922 and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows: Post Operative Shock

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Retroperitoneal Sarcoma

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/29/22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. Adler for Adenis M. D.

6/30/22 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 3rd 1922

20 UNDERTAKER: A. Allen Fuller — ADDRESS: 3517 Sp[illegible] Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

65574 HEALTH DEPARTMENT—CITY OF BALTIMORE 65574

D 65574 CERTIFICATE OF DEATH. 180 D 65574

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. President & Lancaster 3d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. Wallace

(Residence in Baltimore: No. 1516 Lancaster St. St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown (Month) 1 (Day) (Year)

7-AGE, 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country) England

PARENTS.

10-NAME OF FATHER Leonard W. Wallace

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Bertha A. Londes

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha A. Boardman

(Address) Middle River

15- Filed JUL 2 - 1922 ROBERT R. KRAUTER, Burial Permit Writer Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocated by being buried in a pile of shavings & sawdust (Duration) ... yrs. Unknown

CONTRIBUTORY (Secondary) Fell in a bin of shavings & Saw dust - (Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton M. D. (Coroner)

July 1st, 1922 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel

DATE OF BURIAL, 7/3/, 1922

20-UNDERTAKER Wm Cook

ADDRESS 502 E. North ave

Spec.—1-10-21—M&T—1500 Blks.

65575 / 65575

HEALTH DEPARTMENT—CITY OF BALTIMORE

65575 D 65575 X 45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary 16 REGISTERED NO. .....

CITY OF BALTIMORE: (No. Broadway ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Henry Arthur.

(a) RESIDENCE NO. Aberdeen Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) ~~WIFE of~~ the late Etta Wells Arthur

6 DATE OF BIRTH (month, day, and year) 2/5/1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Aberdeen, Md
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) do
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) do
(State or country)

14 Informant Richard A Mew
(Address) Aberdeen Md

15 Filed JUL 2- 1922, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to July 1, 1922, that I last saw him alive on July 1, 1922, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum.

(duration) unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) — yrs. → mos. 6 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of June 25. 22

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) W. L. Rice, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md — DATE OF BURIAL July 3, 1922

20 UNDERTAKER Wm. Trueman Wood — ADDRESS Norfolk Va

N.B.—WRITE PLAINLY, AND ANSWER QUESTIONS FOR THE INFORMATION OF THE REGISTRATION OFFICERS. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

65576 D 65576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65576 D 65576

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 918 N. Gilmor ST., (WARD) 16

2-FULL NAME Elizabeth Thomas Smyth

(a) RESIDENCE No. 918 N Gilmor ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: /

6 DATE OF BIRTH (month, day, and year): Nov 24 1838

7 AGE — Years: 83 Months: 7 Days: 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: Charles Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): A.A. Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Grace A Smith

(Address): Towson Md

15 JUL 2-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 1920, to June 29, 1922

that I last saw h[illegible] alive on June 27, 1922

and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) H. E. Wright, M. D.

6/30, 1922 (Address) 7282. 41 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sharpy A A Co Md — DATE OF BURIAL: July 2 19[illegible]

20 UNDERTAKER: W. J. Tedmon & Sons — ADDRESS: Towson

D 65577

HEALTH DEPARTMENT--CITY OF BALTIMORE

100-001655-77 D 65577

CERTIFICATE OF DEATH

1 PLACE OF DEATH Kernan Hospital for Crippled Children REGISTERED No. C

CITY OF BALTIMORE (No. Hillsdale, Md. ST.: 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mildred W. Smith.

(Residence in Baltimore: No. 1447 Montpelier St.: 17 yrs. 4 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single.

6 DATE OF BIRTH: February 16, 1905 (Month) (Day) (Year)

7 AGE: 17 yrs. 4 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Solon L. Smith

11 BIRTHPLACE OF FATHER (State or country): Cambridge, Md.

12 MAIDEN NAME OF MOTHER: Alice Ellinger

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Solon L. Smith

(Address) 1447 Montpelier St.

15 Filed JUL 2 - 1922, 191 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 1 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 1 1922 that I saw h[illegible] alive on July 1, 1922 and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

1) Broncho Pneumonia
post operative.
2) Stricture,

(Duration) ..... yrs. ..... mos. 22 ds

Contributory (SECONDARY) Congenital Cerebral Diplegia (Duration) Congenital yrs. ..... mos. ..... ds.

(Signed) E. L. Eastman M. D.

July 1, 1922 (Address) Kernan Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 1 mos. ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery DATE OF BURIAL: July 3, 1922

20 UNDERTAKER: Henry Hordon Son ADDRESS: 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65578

CERTIFICATE OF DEATH.

H 3 D 65578

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 533-N-Milton Av ST.; 17 WARD)

2-FULL NAME Anna Northey Price

(a) RESIDENCE. No. 533-N-Milton ST., 7 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Price

6 DATE OF BIRTH (month, day, and year) Oct-11-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Montreal Canada

PARENTS

10 NAME OF FATHER Geo. Northey

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known England

12 MAIDEN NAME OF MOTHER Emily Prouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known England

14 Informant Mr J G Price - (son)

(Address) 9 Birkdale Road - City

15 Filed . 19

JUL 7 - 1922 ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st. 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30th. 1922. to July 1st. 1922

that I last saw him alive on July 1st. 1922

and that death occurred, on the date stated above, at 11:50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinomatous infiltration of intestines. of indefinite duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) "asthenia".

(duration) ? yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no. Date of X

Was there an autopsy? X

What test confirmed diagnosis? Visual conditions and symptoms

(Signed) Claude C. Price, M. D.

, 19 (Address) 1012 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL July 3 1922

20 UNDERTAKER STEWART & MOWER COMPANY (WILLIAM P. WOOD) ADDRESS 1118 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65579

D 65579

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH Elizabethan Apt.

CITY OF BALTIMORE: (No. Garrison & Pulaski ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Fund, Elizabethan Apt,

(a) RESIDENCE NO. ..... ST., ... WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Fund.

6 DATE OF BIRTH (month, day, and year) Nov. 25th 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Candy Mfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Christper Fund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Beta Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Clara Fund Daughter
(Address) Elizabethan Apt.

15 Filed JUL 8 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10th 1922, to June 29 1922,

that I last saw h[illegible] alive on June 29th 1922,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning
(duration) 2 wks. mos. ds.

CONTRIBUTORY (Secondary) Cystitis
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

June 29 1922 (Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 7/3/1922

20 UNDERTAKER: Liston P. Fusselbaugh

ADDRESS: 2620 St Paul St

N. B.—WHILE CLEARLY WRITTEN—THIS IS A LEGAL DOCUMENT AND MUST be filled out in full. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 65580

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65580

CERTIFICATE OF DEATH.

117

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST.: 11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Smith

(a) RESIDENCE. NO. 1014 McCulloh ST., WARD. 35

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Autumn 1887

7 AGE — Years: 35 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer: at Home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Tait

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): James Smith 1014 McCulloch St

15 Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar

Rachel [illegible], Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1922. to June 29, 1922.

that I last saw h[illegible] alive on June 29, 1922.

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

CONTRIBUTORY (Secondary) Suppurative Appendicitis (duration) yrs. mos. 3 ds.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Balto City

Did an operation precede death? Yes Date of June 26, 22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A. Gantt M. D.

(Address) 624 N. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 2 1922

20 UNDERTAKER: Samuel Hemsley — ADDRESS: 524 N Biddle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65581 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65581

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 671 Lowden Ave (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan A. Morgan

(a) RESIDENCE. No. 671 Lowden Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred: 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
F.	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Morgan

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Pat Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER M. Kerrons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant M. Flanagan (Address) 671 Lowden Ave

15 FILED JUL 2 - 1922 ROBERT J. KRAUTER Registrar Registration Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1922

17

I HEREBY CERTIFY, That I attended deceased from June 24 1922, to June 29 1922

that I last saw h[illegible] alive on June 29 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) L. E. Brumbaugh M. D.

6/30/22 (Address) 1531 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 7/3 1922

20 UNDERTAKER J. F. Talbert & Sons ADDRESS 138 Light St.

Spec. 4-29-22 H.D. No.— 1000 Bks.

D 65582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65582

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 N. Regester ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonza E. Ford

(a) RESIDENCE. No. 1615 N. Regester ST., WARD. 8

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Ford

6 DATE OF BIRTH (month, day, and year) Jan 13-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Maryland

PARENTS

10 NAME OF FATHER Charles Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Maryland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Maryland

14 Informant Lena Ford

(Address) 1615 N. Regester st

15 Filed JUL 2- 1922 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1921, to June 30, 1922 that I last saw him alive on June 30, 1922 and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Test of urine

(Signed) Edwin B. Fenby, M. D.

(Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 3 1922

20 UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Volume V 101-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65583

CERTIFICATE OF DEATH.

D 65583

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 N. Washington St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jose D. Y Otero

(Residence in Baltimore: No. 937 N Washington St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1863 (Year)

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stonecutter
(b) General nature of industry, business, or establishment in which employed (or employer): 088

9-BIRTHPLACE, (State or Country) Bohemia

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stella Nickel

(Address) 211 N Chapel St

15- JUL 2- 1922 191..... ROBERT R. [illegible] Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 26 1922, to June 28 1922, that I saw h[illegible] alive on June 28 1922, and that death occurred, on the date stated above, at 4[illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wilbur H. Davis M. D.

June 28 1922, 191... (Address) 848 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cem. DATE OF BURIAL, July 3, 1922

20-UNDERTAKER Jos. J. Kerr ADDRESS 156 N. Luzerne Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65584

CERTIFICATE OF DEATH.

90 D 65584

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 N. Broadway ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary L. Hebb

(a) RESIDENCE. No. 1601 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Stephen Hebb

6 DATE OF BIRTH (month, day, and year) Aug. 29. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Johnstown
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER T. L. Heyer

11 BIRTHPLACE OF FATHER (city or town) Johnstown
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anne J. Matthews

13 BIRTHPLACE OF MOTHER (city or town) Johnstown
(State or country) Pennsylvania

14 Informant Arthur Hebb
(Address) 22 11 E. Lexington St.

15 Filed JUL 2- 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1- 1922, to June 29, 1922;
that I last saw h alive on June 29, 1922;
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

7 yrs. — mos. — ds. (duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar D. Eberbach M. D.

19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	July 3 1922

20 UNDERTAKER ADDRESS

Wm. C. Black 927 N. Broadway

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65585

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 910 Warner St. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Dunlap. (C)

(Residence in Baltimore: No. 910 Warner St. St. yrs. 8 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: Colored.

5-Single, Married, Widowed or Divorced, (Write the word.): Married.

6-DATE OF BIRTH: June 25th. 1894. (Month) (Day) (Year)

7-AGE: 28 yrs. 0 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): South Carolina.

PARENTS.

10-NAME OF FATHER: Zachariah Gregg. (C)

11-BIRTHPLACE OF FATHER, (State or Country): South Carolina.

12-MAIDEN NAME OF MOTHER: Martha Sharper. (C)

13-BIRTHPLACE OF MOTHER, (State or Country): South Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Dunlap. (C) husband.

(Address) 910 Warner St.

15-

Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto H. Bernhardt M. D. (Coroner.)

July 1st 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lynchburg Va. DATE OF BURIAL: July 2 1922

20-UNDERTAKER: Mrs Goldstrom ADDRESS: 406 W Conway St

Spec.-1-10-21 M&T 1500 Bks.

D 65586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 65586

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women of Maryland ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane de Bath Wallach

(a) RESIDENCE NO. 1300 N. Calvert st (Usual place of abode) ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single.

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) 14 November 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John Wallach

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Jane Whelan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs T. E. Whelan (Address) 1300 N Calvert st

15 Filed JUL 2 - 1922 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12th, 1922, to July 1st, 1922.

that I last saw her alive on July 1st, 1922;

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism.

(duration) yrs. mos 10 min. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of June 2nd 1922

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. E. Chatard, M. D.

July 1st, 1922 (Address) 41 W. Biddle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL July 3rd 1922

UNDERTAKER W. J. Jenkins & Son Co ADDRESS Cathedral & Mt. Vernon Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65587 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65587

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Calvert ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frankk Battle Dancy

(a) RESIDENCE. NO. 1117 Calvert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mch	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Grimes Dancy

6 DATE OF BIRTH (month, day, and year) Aug 4. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Manufacturer.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Raleigh N.C

PARENTS

10 NAME OF FATHER Wm. Francis Dancy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tarboro, N.C.

12 MAIDEN NAME OF MOTHER Mary Eliza Battle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Edgecomb Co. N.C.

14 Informant Elizabeth Grimes Dancy
(Address) 1117 N. Calvert

15 Filed JUL 2- 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from —, 1917, to June 30, 1922

that I last saw h. im alive on June 30 1922.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris —

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. W. Bridgman, M. D.

, 19 (Address) 11 E. Chase ST.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh N.C.	July 2nd 1922

20 UNDERTAKER W. W. Jenkins & Sons ADDRESS Oakland Ave-Edenton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65588

CERTIFICATE OF DEATH.

5 117

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Henderson

(Residence in Baltimore: No. 1213 ~~High~~ High al. St.; yrs., 25 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... —
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Henderson

(Address) 1213 High Alley

15-

Filed JUL 2- 1922 191.... J. J. G.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appendicitis 1 day

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 1, 1922 (Address) 1685 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, July 2, 1922

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65589

D 65589

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH 1021

REGISTERED NO.

CITY OF BALTIMORE: (No. 1021 W. Cross ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Frech

(a) RESIDENCE NO. 1021 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Frech

6 DATE OF BIRTH (month, day, and year): Sept 29 1846

7 AGE: Years 73 Months 9 Days c If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer: Sehlers Bros

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Frederick Frech

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George Frech

(Address): 1021 W. Cross St

15 Filed JUL 2-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1922, to July 1, 1922

that I last saw him alive on June 30, 1922

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Morley Stoney M. D.

7/1, 1922 (Address) 729 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 3 1922

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 2178 Ba.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65590

CERTIFICATE OF DEATH.

90 D 65590

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Eager ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Webber

(Residence in Baltimore: No. 1720 Eager St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Sept 14, 1858 (Month) (Day) (Year)

7-AGE, 63 yrs. 9 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Wilson

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Matilda Ritchie

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph C. Webber

(Address) 1720 Eager St

15- Filed JUL 2 - 1922 191 ROBERT R. KNAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1st, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1922, to July 1 1922, that I saw her alive on June 30 1922, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) ..... yrs. ..... mos. 9 hrs

(Signed) W. C. Sandrock M. D.

July 1, 1922. (Address) 1242 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, July 3, 1922

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager

Spec.-1-10-21-M&T-1500 Bks.

1841 Penn Ave Hall 1812

D 65591

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 1812 D 65591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1552 Penn Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME, Samuel McCauley

(a) RESIDENCE NO. 1552 Penn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie M. McCauley

6 DATE OF BIRTH (month, day, and year): Aug 28 1854

7 AGE: Years 67; Months 10; Days 2; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 088

(c) Name of employer: Smith & Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuel McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt-

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Grace McCauley 1552 Penn Ave

15 Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 1922, to June 30th, 1922, that I last saw him alive on June 28th, 1922, and that death occurred, on the date stated above, at 6-a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ✓ yrs. ✓ mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral Pressure (duration) ✓ yrs. ✓ mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? General Symptoms only

(Signed) J. T. T. Hancock, M. D.

, 19 (Address) 1812 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: July 3 1922

20 UNDERTAKER: H. W. Cook

ADDRESS: Md. Gen. Hosp.

Attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65592 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D 65592

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Behrens

(Residence in Baltimore: No. 2408 Barclay St.; yrs. 4/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 4 (Day) 1859 (Year)

7-AGE, 63 yrs. 1 mos. 26 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Bernard Behrens

11-BIRTHPLACE OF FATHER, (State or Country), France

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah D. Behrens

(Address) 2408 Barclay St.

15- Filed JUL 2 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 30 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Strangulation
Self Inflicted
Necks

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John F. Morrison M. D.
(Coroner.)

July 1 1922 (Address) 3632 Roland ave

*State the Disease Causing Death, or, In deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, July 3, 19 22

20-UNDERTAKER, William Cook — ADDRESS 507 E. North ave

Dr Morrison 3632 Roland ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Add should be stated EXACTLY. PHYSICIANS should is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 65593 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65593

CERTIFICATE OF DEATH. 112

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (No. 1415 N. Bentalou St., 15 WARD)

2-FULL NAME Virginia C. Nelter

(a) RESIDENCE NO. 1415 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of John F. Nelter

6 DATE OF BIRTH (month, day, and year) July 18 1862

7 AGE Years 59 Months 11 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER Clement Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen McFaul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Leonora Nelter.

(Address) 1415 N. Bentalou

15 Filed JUL 2-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 22, to July 1st 19 22.

that I last saw h alive on June 30th 19 22,

and that death occurred, on the date stated above, at 6 AM.

The CAUSE OF DEATH* was as follows: Chronic Nephritis. (Contributory)

(duration) 5 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Exhaustion Natural

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Elsbach M. D.

7-1. 1922 (Address) 607 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 7/4 1922

20 UNDERTAKER W. M. Cook — ADDRESS 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65594 D 65594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Chesel Home and Infirmary

CITY OF BALTIMORE: (No. 176 N. Broadway ST., 12 WARD)

REGISTERED NO. 4246

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Florence E. Robinson

(a) RESIDENCE No. 2121 N. Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

Calvert Co Md

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Robinson

6 DATE OF BIRTH (month, day, and year) Jan 23 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) R. Calvert-Co Md.

PARENTS

10 NAME OF FATHER R E King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md.

12 MAIDEN NAME OF MOTHER Margaret Schriver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Mrs. Robinson

(Address) 2121 N. Calvert St

15 Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24 1922 to July 1 1922, that I last saw h e alive on July 1 1922, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

(duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary) Acute dilatation Heart - Anuria (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 26 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Richard G. Coblentz, M. D.

1922, 19 (Address) Chesel Home and Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Central Cemetery Calvert Co Md

DATE OF BURIAL July 3 1922

20 UNDERTAKER H E Hughes

ADDRESS 4 & N. Broadway

Nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

John Hayden.

D 65595

HEALTH DEPARTMENT—CITY OF BALTIMORE

1903

D 65595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bay View Hospital St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME John J Hagdess

(Residence in Baltimore: No. 1825 Aliceanna St Cambridge St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, October (Month) 9. (Day) 1891. (Year)

7-AGE, 31 yrs. mos. ds.

If LESS than 1 day, hrs. or mts.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Stevedore Pa-R.R. (b) General nature of industry, business, or establishment in which employed (or employer): 074

9-BIRTHPLACE, (State or Country), Fredricksburg. Va.

PARENTS.

10-NAME OF FATHER, John Hayden.

11-BIRTHPLACE OF FATHER (State or Country), Fredricksburg. Va.

12-MAIDEN NAME OF MOTHER Elizabeth Gartley.

13-BIRTHPLACE OF MOTHER (State or Country), Fredrikcburg. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Hayden

(Address) 182 S. Aliceanna St

15-JUL 2-1922 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Jumped off back of auto truck while in motion

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

July 1st, 1922 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, July 4th, 1922.

20-UNDERTAKER M. F. Ludowski ADDRESS 705 S. Ann St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65596

CERTIFICATE OF DEATH.

46 D 65596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 E Preston ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Lieder

(a) RESIDENCE NO. 1606 E Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fredk W. Lieder Jr

6 DATE OF BIRTH (month, day, and year): July 25 1860

7 AGE: Years 62 Months 4 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Aug Ehoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Wilhelmine Stade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant (Address): Fredk W. Lieder 1606 E Preston

15 Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1920, to June 30, 1922

that I last saw her alive on June 30, 1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Microscopical Diagnosis Squamous cell carcinoma of Cervix

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 27/1920

Was there an autopsy? No

What test confirmed diagnosis? Operation & Microscopical Examination

(Signed) Edward F. Smith, M. D.

19 (Address) 16 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

DATE OF BURIAL: July 3 1922

20 UNDERTAKER

ADDRESS 2008 Eutaw

INSTRUCTIONS. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 710 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjorie Kendall

(a) RESIDENCE NO. 125 Collins Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) May 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lavy A. Kendall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Pittman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Local

15 Filed JUL 2- 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 - 1 - 1922

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1922, to July 1, 1922.

that I last saw her alive on July 1 - , 1922,

and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wt. 3 lbs -

(Signed) Horace G. Stewart, M. D.

7/1, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL July 3 1922

20 UNDERTAKER J Sullivan

ADDRESS 2008 Aliceanna

Attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65598

CERTIFICATE OF DEATH.

57 D 65598

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3821 Roland Ave ST., 13 WARD)

2-FULL NAME Margaret A. Summer

(a) RESIDENCE NO. 3821 Roland Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Summer

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: H. B. Hossfross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary J. ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Ena M. Davis

(Address): 3821 Roland Ave.

15 Filed JUL 2 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1922 to July 1, 1922

that I last saw her alive on June 31, 1922

and that death occurred, on the date stated above, at 3:50 A m.

The CAUSE OF DEATH* was as follows:

Septicemia

Gangrene of left foot

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Diabetis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? - No -

What was confirmed diagnosis? Clinical

(Signed) T. W. Hastings M.D.

7-6 1922 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Augustine Cem. Elkridge

DATE OF BURIAL: July 3 1922

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 363 Hall Rd.

CAUSE SHOULD BE CERTAINLY STATED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65599

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65599

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward) 24 x 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Albert S. Palmer.

(Residence in Baltimore: No..... Soldiers' Home Hampton Va. St.; yrs.....mos.....ds.)

En route.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Widower.

6-DATE OF BIRTH. Do not know. ....., 1..... (Month) (Day) (Year)

7-AGE. 73 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Pensioned Soldier.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Pennsylvania.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry P Harvey. (nephew).

(Address) 2335 Logan St. Harrisburg Pa.

15- Filed JUL 3- 1922 ROBERT R. KNAUER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1st. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) H. Tilghman Feinhardt M. D. (Coroner.)

July 2- 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; aud (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Harrisburg Pa	July 2nd, 1922
20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

√ 65999

D 65600 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 65600

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Mount ST.: 14 WARD)

2-FULL NAME Charles Fuller

(a) RESIDENCE. NO. 225 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colrd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Nov. 20. 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fulton Laundry - Laundry

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Warsaw Fuller

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Green

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant Ana Etheridge (Address) 225 N. Mount

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to June 29, 1922, that I last saw h~~im~~ alive on June 29, 1922, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Occupation - Exhaustion

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary - Physical

(Signed) William A. Wright, M. D.

June 30, 1922 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 2 1922

20 UNDERTAKER Edward Ringgold ADDRESS 1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65601

CERTIFICATE OF DEATH.

REGISTERED NO. 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Lilly.

(a) RESIDENCE. No. 310 S. 6th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 8-1920

7 AGE — Years: 1 — Months: 7 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Howard Lilly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Ida Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md

14 Informant: Howard Lilly
(Address): 310 S 6th St

15 FILED: JUL 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to July 2, 1922, that I last saw h[illegible] alive on July 2, 1922 and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) — yrs. — mos. 24 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia ?

(duration) — yrs. — mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M D, M. D.

7/2/22 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: July 3 1922

20 UNDERTAKER: J Merrick

ADDRESS: 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65602

D 65602

CERTIFICATE OF DEATH.

D 65602

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 45 S. Schroeder ST.: 18 WARD)

2-FULL NAME Mary Aloysius Burke

(a) RESIDENCE. NO. 45 S. Schroeder ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12 - 86

7 AGE: Years 36. Months 5 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Michael Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Dowling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Michael Burke

(Address): 45 S. Schroeder St.

15 JUL 3 - 1922 ROBERT R. KRAUTER (Registrar)

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 23rd, 1922, to July 2nd, 1922, that I last saw her alive on July 2nd, 1922, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) — yrs. — mos. 1/8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Hart, M. D.

, 19 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: July 19

20 UNDERTAKER: Edward Lee Edwards

ADDRESS: 501 Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65603

CERTIFICATE OF DEATH.

1 00 65603
5 D 65603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 25 WARD)

2-FULL NAME James Edward McEvoy

(a) RESIDENCE. No. Mount Hope Retreat ST.; 25 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	57.	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph McEvoy

11 BIRTHPLACE OF FATHER (city or town) Dublin (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McEvoy

13 BIRTHPLACE OF MOTHER (city or town) Dublin (State or country) Ireland

14 Informant Receiver of Mt Hope Retreat (Address) Mt Hope Retreat

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Jul 1893, 19—, to July 1, 19—, that I last saw h— alive on June 1, 1922, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis -

abt (duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Chr. Dementia -

abt (duration) 27 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	July 5th 1922
20 UNDERTAKER John J. Cowan & Son (Per H J Cowan)	ADDRESS 301 N Gilmor St

MEDICAL EXAMINER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

00165604

D 65604

CERTIFICATE OF DEATH.

K74 D 65504

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1224 Jefferson ST., 18 WARD)

2-FULL NAME William H. Williams

(a) RESIDENCE NO. Ocean City Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 45; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boardinghouse

(b) General nature of industry, business, or establishment in which employed (or employer): 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Worcester Co Md

PARENTS

10 NAME OF FATHER: Wm Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Worcester Co Md

12 MAIDEN NAME OF MOTHER: Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Worcester Co Md

14 Informant: Lucy Williams

(Address) 1224 Jefferson St

15 Filed JUL 3 - 1922 ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17 - 1922 to July 1 1922

that I last saw him alive on June 30 1922

and that death occurred, on the date stated above, at 5.35 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

asthma & dropsy.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Asthma Dropsy & Complication Disease (duration) yrs. 27 mos. 18 ds.

18 Where was disease contracted if not at place of death? Ocean City Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D G W Kenyard, M. D.

7-2, 1922 (Address) 708 Carson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ocean City Md — DATE OF BURIAL: Jul 3 1922

20 UNDERTAKER: Daniel Coulbourn — ADDRESS 916 Pa.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 65605

H3

CERTIFICATE OF DEATH.

D 65605

D 65605

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Sebastian Harris

(a) RESIDENCE NO. 630 Josephine ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt City Md

PARENTS

10 NAME OF FATHER Dont Remember

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know ?

12 MAIDEN NAME OF MOTHER Dont Know ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know ?

14 Informant David Easton

(Address)

15 Filed JUL 3 - 1922 19 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1922 to June 30, 1922, that I last saw him alive on JUNE 30, 1922, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right side of tongue

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) G Richardson Jones M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL July 4 1922

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

REGISTRAR'S STAMP MUST be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 65606

31 D 65606

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Brewer ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Glexander Smith

(a) RESIDENCE. No. 1102 Brewer ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Bell Smith

6 DATE OF BIRTH (month, day, and year) Aug 16, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Rosa Bell Smith (Address) 1102 Brewer St

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7 1922, to June 30 1922

that I last saw him alive on June 29 1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Interculosis of the Lungs.

(duration) About yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autum Exam.

(Signed) J. L. Shelton, M. D.

6/30, 1922 Address 703 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 3 1922

20 UNDERTAKER David Eaton ADDRESS Dear

Spec.—6-9-19—H. P. Co.—1000 Bks.

Martha Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65607

CERTIFICATE OF DEATH.

REGISTERED NO. 174

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 Myrtle Ave ST. 17 WARD)

2-FULL NAME Martha Brown

(a) RESIDENCE. NO. 1033 Myrtle Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE — Years: 65 yrs. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't know

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't know

14 Informant (Address): Mrs Ella Tate. 1033 Myrtle ave

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25 1922 to July 1 1922 that I last saw h alive on " 1 1922 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia 0720

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. H. Melone M. D

, 19 (Address) 1305 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 3 22

20 UNDERTAKER: David Carlin — ADDRESS: 716 Pa ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic. Terminal hemorrhage.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65608

CERTIFICATE OF DEATH.

31 D 65608

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 N. Bruce st ST.: 15 WARD)

2-FULL NAME Hattie M. Peters

(a) RESIDENCE. No. 1522 N. Bruce St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Thomas F. Peters

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Pelland

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Thos. F. Peters (Father)

(Address) 1522 N. Bruce St.

15 JUL 3 - 1922 ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30 1922

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 30, 1922, that I last saw her alive on June 30, 1922, and that death occurred, on the date stated above, at 4:15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) about yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cremona Cemetery	July 2 1922
20 UNDERTAKER James H. Dennis.	ADDRESS 1303 Eutaw

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65609

REGISTERED NO. 1291 D 65609

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 N. Milton ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wise

(a) RESIDENCE. No. 1621 N. Milton ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Wise

6 DATE OF BIRTH (month, day, and year) May 13-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker off 3

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anne E. Loos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Wise (Address) 1621 N. Milton ave.

15 JUL 3 - 1922 ROBERT A. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to June 30, 1922, that I last saw h alive on June 30, 1922, and that death occurred, on the date stated above, at 7 20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Interstitial ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? (

Did an operation precede death? (Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Carrasco M. D.

(Address) July 3 1922 3450 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	July 3 1922

20 UNDERTAKER Wm. C. Black 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1882 001

D 65610

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. B & O. R.R. Pier – Fort Fells ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. H. Henderson

(Residence in Baltimore: No. 1735 McCullough St

..St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 7 1879
(Month) (Day) (Year)

7-AGE, 42 yrs. 7 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Capt. Steamboat "Charlotte"
(b) General nature of industry, business, or establishment in which employed (or employer) D.&C.

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John W. Henderson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary G. Scott

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Henderson

(Address) 1735 McCullough St

15 Filed JUL 3 – 1922, 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH was as follows:

Internal Hemorrhage

Died at once

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Wheel of Box Car Broke passed over body –

(Duration) ....yrs.....mos.....ds.

(Signed) Thos. B. Horton M. D.

(Coroner)

July 1st, 1922 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, July 3 1922

20-UNDERTAKER, Samuel Hemsley — ADDRESS 1138 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dwer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65611

CERTIFICATE OF DEATH.

D 65611

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 - 9th St Mount Park WARD 25)

2-FULL NAME William F Dwer Jr (6½ mo)

(a) RESIDENCE. No. 1212 - 9th St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	no	no	no	6 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Dwer Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Bell July 2

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Dwer (Address) Morrill Park

15 JUL 3 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to July 1, 1922, that I last saw him alive on July 1, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6/2 Months

(duration) no yrs. no mos. 6 hrs.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Premature Birth

(Signed) R. O. Adams, M. D.

July 2, 1922 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL 7/3/22

20 UNDERTAKER W J Tilmon & Son ADDRESS Penna Ave North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-65612

CERTIFICATE OF DEATH.

74-001 D 65612

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 N Bond ST., 8 WARD)

2-FULL NAME Fannie E. Crate

(a) RESIDENCE NO. 1112 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Frederick T Crate

6 DATE OF BIRTH (month, day, and year) Feby 14th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alexander A Bossom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary A Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Mamie E Crate (Address) 1112 N. Bond st

15 Filed JUL 3 - 1922 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from November, 1921, to June 1, 1922, that I last saw h[illegible] alive on " " , 1922 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy with right hemiplegia

(duration) 13 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George C. McHarrison M. D.

1922 (Address) 2214 Mansfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL July 4th 1922

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 Edmonson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65613

CERTIFICATE OF DEATH.

113

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 W. West St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Debora H. Spence. (C)

(Residence in Baltimore: No. 115 W. West St. St.; yrs. 4 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH. March 1st. 1922. (Month) (Day) (Year)

7-AGE. ---- yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): Off

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS

10-NAME OF FATHER. Frank Spence. (C)

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Louise Anderson. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Spence. (C) mother.

(Address) 115 W. West St.

15 JUL 3 - 1922 ROBERT R. KRAUTER, Registrar.
Filed ..... 19.. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

July 2nd 19 2 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn	July 3 19..
20-UNDERTAKER,	ADDRESS
L. L. Brown's Son	1017 W. Baltimore

If a case of death from any CONTAGIOUS DISEASE, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65614

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. D 65614

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Becks Lane ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M. Berry

(a) RESIDENCE. No. 2303 Becks Lane ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: w. | 5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Walter Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elsie Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Elsie Matthews (Address) 2303 Becks Lane

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922, to July 1, 1922, that I last saw h alive on June 30, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James R Bolgiano M. D.

7/3 1922 (Address) 1729 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	July 3 1922

20 UNDERTAKER ADDRESS

John J Cowan & Son 901 Hollins St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65615
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

57 D 65615
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1264 E Mont Ave St., 9 WARD)

2-FULL NAME Mary E Valentine

(a) RESIDENCE NO. 1264 E Mont Ave St., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. 10 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis G Valentine

6 DATE OF BIRTH (month, day, and year) Sept 23rd 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John C. Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Margaret Getz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Francis G. Valentine
(Address) 1264 E. Mont Ave

15 Filed JUL 3 - 1922 ROBERT H. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1920, to July 2nd, 1922, that I last saw her alive on July 2nd, 1922, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? Yes Date of 2

Was there an autopsy? No

What test confirmed diagnosis? Chem. & Microscop. Ex.

(Signed) August Horn M. D.

, 19 (Address) 408 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 5th 1922
20 UNDERTAKER E. Schlossman & Son	ADDRESS 1034 Edmondson Ave

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Blanks should be correctly supplied. ALL should be filled EXACTLY. PHYSICIANS should read

Spec.—1-10-21—M&T—1500 Bks.

D 65616 ~~D 65616~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. D 65616

CITY OF BALTIMORE: (No. ..... ST., 47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lee.

(a) RESIDENCE No. 602 Bradley Av City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~and WIFE of~~ Hattie Lee wife,

6 DATE OF BIRTH (month, day, and year): May 3 1873

7 AGE: Years 49. Months ?. Days ?. If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster.

(b) General nature of industry, business, or establishment in which employed (or employer): 23

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ?

12 MAIDEN NAME OF MOTHER: Elizabeth Hugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address) Reported

15 JUL 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922, to July 1, 1922, that I last saw him alive on July 1, 1922, and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Auricular Flutter

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Syphilis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. Sidney Burwell, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lubumbenity — DATE OF BURIAL: July 3 1922

20 UNDERTAKER: W. M. Routson — ADDRESS: 230 N Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65617.

CERTIFICATE OF DEATH.

90 D 65617.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N - Eden ST., 5 WARD)

. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Frisby

(a) RESIDENCE NO. 520 N - Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5-0	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Stephen Frisby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Jane Elicke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

14 Informant John Frisby
(Address) 520 N Eaden St

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-1922

17 I HEREBY CERTIFY, That I attended deceased from 4-5-, 1922, to 6-30-, 1922, that I last saw him alive on 6-30-, 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nabvulitis

Indefinate
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebrospinal Meningitis Indefinate
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed djagnosis? —

(Signed) W. A. Cargill M. D.

7-7-1922 (Address) 611 - N - Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Adlers Cemetery	July 3 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Av

• CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65618

D 65618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 18 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Brandt.

(a) RESIDENCE No. 824 Cloney St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Anthony Brandt,

6 DATE OF BIRTH (month, day, and year): October 18, 1841

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles F.W.Waidner,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Brandt.

(Address): 824 Cloney St

15 Filed JUL 5 - 1922 19..

ROBERT R. KRAUTER. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1922 to July 2, 1922.

that I last saw her alive on July 2, 1922

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S. Lab

(Signed) John J. Sazerlucki M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: July 4, 1922

20 UNDERTAKER: Geo W Little

ADDRESS 2700 Edmondson a

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Boehm

15-6434.

D 65619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65619

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. .... ' ' ' ' ST., 7 WARD)

2-FULL NAME Harry Bochm.

(a) RESIDENCE NO. 2512 E. Register St. City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White, Color

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Lily Bochm (mother)

6 DATE OF BIRTH (month, day, and year) May 24, 1922

7 AGE — Years: — Months: 1 Days: 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: John Bochm.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md

12 MAIDEN NAME OF MOTHER: Lily Gobble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL Reside.

15 Filed JUL 5 1922 ROBERT R. KRAUTER, Registrar

JUL 5 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to July 2, 1922, that I last saw him alive on July 2, 1922, and that death occurred, on the date stated above, at 12½ P. m.

The CAUSE OF DEATH* was as follows:

Meningeal Hemorrhage

(duration) ... yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) Diarrhoea - Not dysentery

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Edward Mason, M. D.

7/2, 19 22 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dallo Cemetery — DATE OF BURIAL: July 3, 19 22

20 UNDERTAKER: Louis Hamann — ADDRESS: 32 S Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65620

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2357 N Arlington Ave St., 6 WARD)

2-FULL NAME William W. Wilson

(a) RESIDENCE NO. 2357 N Arlington Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

129 D 65620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE) Lydia Wilson

6 DATE OF BIRTH (month, day, and year) Oct 4, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel 086

(c) Name of employer P. R. R.

9 BIRTHPLACE (city or town) (State or country) Danville Virginia

PARENTS

10 NAME OF FATHER Adolphus Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Milton N.C.

12 MAIDEN NAME OF MOTHER Janie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rockingham Virginia

14 Informant Janie Wilson

(Address) 2357 N Arlington ave

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk, (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to July 1, 1922, that I last saw h[illegible] alive on June 30, 1922, and that death occurred, on the date stated above, at 12.55 a m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 2 days ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Neville M. D.

7/11, 1922 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL July 3 1922

20 UNDERTAKER Julius B Pyle — ADDRESS 102 E. Mulberry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65521

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery and Childs Hospital ST. 11 WARD)

2-FULL NAME Harold Becker

(a) RESIDENCE. NO. 2253 West Baltimore Street ST. ..... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Victor Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Sophia Zuckerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records
(Address)

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/22 19

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to July 3, 1922, that I last saw him alive on July 2, 1922, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion

(duration) 0 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Acidosis

(duration) 0 yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac F. Haines Co. M. D.

19 (Address) 2002 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	7-3- 1922

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

Frank Mahn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65622

CERTIFICATE OF DEATH.

161-81

D 65622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Ridgley St.; 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Mahn

(Residence in Baltimore: No. 1006 Ridgley St.; ....yrs.,....mos.....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 2, 1922 (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds.

If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank Mahn

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Florina Connelly

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Mahn

(Address) 1006 Ridgley St

15-

Filed JUL 3 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1922 to July 2 1922, that I saw h.. alive on July 2 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Congestion

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) 0 (Duration) ....yrs. ....mos. ....ds.

(Signed) Wm H Schwaneberg M. D.

July 2 1922 (Address) 11 W Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, July 4, 1922

20-UNDERTAKER H. C. Sanderson Son — ADDRESS Roland Ave

Spec.—1-10-21—M&T—1500 Bks.

156841 D 65623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 D 65623

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ... ST., 6 WARD)

2-FULL NAME Mary Louise Brockmeyer

(a) RESIDENCE NO. 1640 N. Wolfe St City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~or) WIFE of~~ Marie Brockmeyer (mother)

6 DATE OF BIRTH (month, day, and year) Feb. 13 1922

7 AGE: Years — Months 4 — Days 19. — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Brockmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Marie Fries

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL Records

15 Filed JUL 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922 to July 2, 1922, that I last saw her alive on July 2, 1922, and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery - Bacillary

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Cultures

(Signed) Glenn Mason, M. D.

7/2, 1922 (Address) J.H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cemetery Belair Rd Mt Carmel

DATE OF BURIAL: July 3rd 1922

UNDERTAKER: Henry Hoen Son

ADDRESS: 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65624

CERTIFICATE OF DEATH.

D 65624

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S.V.HOSP.#56,

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 24 WARD)

2-FULL NAME WILLIAM ASKEW,

(a) RESIDENCE NO. 236 Craig St. Norfolk, Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs.William Askew

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	-	-	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant HOSPITAL RECORDS
(Address) Ft.McHenry,Md.

15 Filed JUL 3 - 1922 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov.19, 1921, to June 30 1922.

that I last saw him alive on June 30 1922,

and that death occurred, on the date stated above, at 7:10 p m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis far advanced and active

- (duration) - yrs. - mos ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis enteritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No. Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinic.& Lab.Reports

(Signed) H.D.LUSE, Surgeon(R), M. D.

6/30. 1922 (Address) U.S.V.Hosp.#56, Ft.McHenry,Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL July 3, 1922

20 UNDERTAKER L. Quinn & Bro — ADDRESS 1127 E. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

D 65625 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

176 D 65625

REGISTERED NO.

1-PLACE OF DEATH Woman's Hospital 215 E 26th St

CITY OF BALTIMORE: (No. Woman's Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mabel Fink

(a) RESIDENCE No. 215 E 26½ St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Fink

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md Jy.

PARENTS

10 NAME OF FATHER Edward Roode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Jy.

12 MAIDEN NAME OF MOTHER Ruth Strange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Jy.

14 Informant C Harley Fink

(Address) 215 E 26½ St

15 JUL 3 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit C[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 2, 1922, that I last saw her alive on July 2, 1922, and that death occurred, on the date stated above, at 12 35 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary) Pelvic operation done at Patient's Home before admission to Hospital

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of June 19 ? 1922

Was there an autopsy? no

What test confirmed diagnosis? Signs and Symptoms

(Signed) EE Duncan M. D.

7/2, 1922 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

(over)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York. DATE OF BURIAL July 3 1922

20 UNDERTAKER Martin Funeral Home ADDRESS 1821 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 65626

PLACE OF DEATH

CERTIFICATE OF DEATH

137 D 65626

REGISTERED NO.

CITY OF BALTIMORE (No. 533 Washington Ave.(Brooklyn) St. 25 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Alice Upton

(Residence in Baltimore: No. 533 Washington Ave.(Brooklyn) St.: 3 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: November (Month) 27 (Day), 1867 (Year)

7-AGE: 54 yrs. 7 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE (State or country): Sykesville Carroll Co.Md.

PARENTS

10-NAME OF FATHER: James E.Collins

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah Robinson

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edmund I.Upton

(Address) 533 Washington Ave.

15 FILED JUL 3 - 1922

ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 30 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1922, to June 30 1922, that I saw her alive on June 30, 1922, and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Left)

(Duration) 1 yrs. mos. 10 ds

Contributory (SECONDARY) Chronic Interstitial Nephritis (Duration) 1 yrs. mos. ds.

(Signed) William A. Lentz M. D.

July 4, 1922 (Address) 816 Cunningham

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill

DATE OF BURIAL: July 3, 1922

20-UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65627

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

179

D 65627

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 738 Light St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Sauerhoff

(Residence in Baltimore: No. 738 Light St.: 75 yrs. 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: February (Month) 24 (Day), 1847 (Year)

7-AGE: 75 yrs. 4 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

037

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Samuel Jones

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah Clemmance

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William P. Sauerhoff

(Address) 738 Light St.

15-

Filed JUL 3 - 1922 ROBERT R. KNAUER, REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 1 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to July 1, 1922

that I saw her alive on July 1, 1922

and that death occurred on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Old age.

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Bright Disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. Edw. Sutcliffe M.D.

7/1, 1922 (Address) 710 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill

DATE OF BURIAL: July 5, 1922

20-UNDERTAKER: John F. Denny

ADDRESS: 715 Light St.

D 65628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65628

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3521 Gough St., N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl D. Myers.

(Residence in Baltimore: No. 3521 Gough St. St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male ~~Female~~

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. May 25 1921
(Month) (Day) (Year)

7-AGE. 1 yrs. 1 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE. (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER. Charles F. Myers

11-BIRTHPLACE OF FATHER. (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER. Anna L. Wilka

13-BIRTHPLACE OF MOTHER. (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles F. Myers

(Address) 3521 Gough St.

15- JUL 3 - 1922 Filed ..... 192 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 2 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Bloades M. D.
(Coroner.)

July 2 192 2 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Carmel Cemetery DATE OF BURIAL. July 3 1922

20-UNDERTAKER. H. Sanders & Sons ADDRESS 1710 Pennsylvania Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65629

D 65629

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1835 Harford Ave ST., 8 WARD)

2-FULL NAME John J. Doyle

(a) RESIDENCE NO. 1835 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Doyle

6 DATE OF BIRTH (month, day, and year) Dec 16 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Sharpe & Dohme

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Delia Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary L. Doyle (Address) 1835 Harford Ave

15 JUL 3 - 1922

ROBERT R. KRAUTH, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 2, 1922, that I last saw him alive on July 2, 1922, and that death occurred, on the date stated above, at 12-30 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

7/2/1922 (Address) 1223 N. Carolina st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: July 5 1922

20 UNDERTAKER: A. Sanders Sons — ADDRESS: 710 Fleet St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65630

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Boston ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Emory

(a) RESIDENCE NO. 2308 Boston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Emory

6 DATE OF BIRTH (month, day, and year) Jan 19, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 10 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant John H. Emory (Address) 2308 Boston St

15 JUL 3 1922 ROBERT A. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to July 2, 1922, that I last saw him alive on July 2, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy? -

What test confirmed diagnosis

(Signed) Edgar K. Otterey M. D.

July 3, 1922 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	July 1922
20 UNDERTAKER	ADDRESS
A. Sanders & Sons	710 Fleet St

HEAD should be Cemetery supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65631

CERTIFICATE OF DEATH.

D 65631

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1544 Woodyear ST., 15 WARD)

2-FULL NAME Charles Henry Agnes

(a) RESIDENCE NO. 1544 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Agnes

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Parker

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant John Agnes
(Address) 1544 Woodyear

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
JUL 3 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to July 2, 1922.

that I last saw him alive on July 2, 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

7/2. 1922 (Address) 1928 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn | DATE OF BURIAL July 3 1922

20 UNDERTAKER Edward Ruggold | ADDRESS 1463 Cam

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65632 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65632

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard + Green ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Earl Heubeck.

(a) RESIDENCE. No. Baynesville Towson Md.
(Usual place of abode)
Length of residence in city or town where death occurred — mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 14, 1899.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23 yrs.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milling Machanic. 046

(b) General nature of industry, business, or establishment in which employed (or employer) General Machine Work

(c) Name of employer Mr. Frank W. Tiles.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leo H. Heubeck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mattie Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Hospital Records,
(Address)

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1922, to July 3, 1922

that I last saw h im alive on July 3, 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of the (Gan) left foot.

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Tetanus

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) [illegible] M. D.

7/3 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Towson Md	7/4/22
20 UNDERTAKER Leo F. Conrad Son	ADDRESS 118 W Mt Royal

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

65633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65633

CERTIFICATE OF DEATH.

113 D 65633

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Carey

(a) RESIDENCE NO. 412 Ann ST., WARD E. B. M.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
F	W	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child 000
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Elsie J. Carey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Mortona McBoneille

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2 , 1922 , to July 2 , 1922 , that I last saw h er alive on July 2 , 1922 , and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea - Not dysentery

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elsie Mason, M. D.

July 2, 1922 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL July 4 1922

20 UNDERTAKER Lilly & Quinn — ADDRESS Hard. Way & Le

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65634

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 311 E. Thirteenth ST., 26th WARD)

2-FULL NAME Lena E. Martell.

(a) RESIDENCE NO. 311 E. Thirteenth ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander H. Martell.

6 DATE OF BIRTH (month, day, and year) June 11th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Michael Adams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Shorr.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Alexander H. Martell

(Address) 311 E Thirteenth St.

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 18th, 1922, to July 3rd, 1922.

that I last saw h[illegible]ive on July 1 22

and that death occurred, on the date stated above at 6 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb H. Athey M. D.

July 3 1922 (Address) 100 S. Potters or Parkwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: July 5th 1922

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 4003 Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Paskowski

D 65635 HEALTH DEPARTMENT—CITY OF BALTIMORE 65635

CERTIFICATE OF DEATH.

113 D 65635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1335 Andre ST., 24 WARD)

2-FULL NAME Dorothy Josephine Paskoski

(a) RESIDENCE NO. 1335 Andre ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 12 1921

7 AGE Years — Months 8 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Paskowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Kurz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry Paskowski (Address) 1335 Andre St

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to July 2, 1922.

that I last saw h alive on July 1, 1922,

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Uremic Colitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Time of disease

(Signed) Walter C Bacon, M. D.

7/2, 1922 (Address) 100 E 20 00 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 7/4 1922

UNDERTAKER William Paskowski

ADDRESS 165 East

IMPORTANT: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Istvan

Spec.—6-9-19—H. P. Co.—1000 Bks.

65636 D 65636

HEALTH DEPARTMENT—CITY OF BALTIMORE

65636

CERTIFICATE OF DEATH.

4 K 101-001

D 65636

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Istvan

(a) RESIDENCE. No. Charlotte Hall Md. WARD. Charlotte Hall Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5th May 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant, nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte Hall Md.

PARENTS

10 NAME OF FATHER Joseph Istvan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungaria.

12 MAIDEN NAME OF MOTHER Mamie Buckler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Joseph Istvan (Address) Charlotte Hall Md.

15 Filed JUL 4 - 1922 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to July 2, 1922, that I last saw h[illegible] alive on July 2, 1922, and that death occurred, on the date stated above, at 3.00 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteric Intoxication.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia, Acidosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Charlotte Hall Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. E. Wells, M. D.

19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bryn Mawr Cem.	July 4 1922

20 UNDERTAKER John Grebliauckas ADDRESS Charlestown Md. 425 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65637.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65637.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 440 E. North Ave ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha A. Springer.

(Residence in Baltimore: No. 440 E. North Ave. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married.

6-DATE OF BIRTH, Apr. 2, 1857
(Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor.
(b) General nature of industry, business, or establishment in which employed (or employer): USN

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha A. Springer.

(Address) 440 E. North Ave.

15-

FILED JUL 4 - 1922 191.. ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. Morrissey M. D.
(Coroner.)

July 3 1922 (Address) 7432 Belair Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Parkwood Cem.	July 4, 1922
20-UNDERTAKER Richard F. Curley	ADDRESS 438 E. North Ave

N.B.—EVERY item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65638

CERTIFICATE OF DEATH.

D 65638

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5215 Elmora Ave. (Ward) 154

ST.: Belvedere

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archie Stubbins

(a) RESIDENCE. No. 5215 Elmora Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year): June 25 1922

7 AGE: Years Months Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore City 5215 Elmora Ave

PARENTS

10 NAME OF FATHER: Elmer Stubbins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Elmer Stubbins (Address) 5215 Elmora Ave

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922 to July 3, 1922

that I last saw him alive on July 2, 1922

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Tartum Pneumonia

Acute Pleurisy.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. N. Buckley, M. D.

, 19 (Address) 126 W Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lutheran Cemetery Md Dulaney Park Road Baltimore Co

DATE OF BURIAL: July 4 1922

20 UNDERTAKER: W M Routson

ADDRESS: 2238 N. Howard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65639 D 65639

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH University Hospital.

CITY OF BALTIMORE: (No. Lombard & Green Sts.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Etta Hughes.

(a) RESIDENCE. NO. 421 N. Bethel St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Negro	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Allen Hughes.

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Allen Hughes (Address) 421 N. Bethel St.

15 JUL 4 - 1922 ROBERT R. KRAUSER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1 1922.

17 I HEREBY CERTIFY, That I attended deceased from 6/26/, 19 22 to 7/1/, 19 22, that I last saw h. alive on 7/1/, 19 22, and that death occurred, on the date stated above, at 12:20 A.M.

The CAUSE OF DEATH* was as follows:

Diabetic acidosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? clinical findings

(Signed) Iron Fredson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Asbury Cem.	July 3rd.

20 UNDERTAKER Henry A. Vodrey ADDRESS Cumberland, Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65640

CERTIFICATE OF DEATH.

D 65640

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. End of Bellevieu Ave (Raspeburg) ST., 32 WARD)

2-FULL NAME Jacob Hubler

(a) RESIDENCE NO. End of Bellevieu Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of the late (or) WIFE of Elizabeth Hubler

6 DATE OF BIRTH (month, day, and year) May 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	71	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Hubler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Gerst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna M. Bauer (Address) End of Bellevieu Ave

15 Filed JUL 4 - 1922 ROBERT H. KRAUTER Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1922

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1922 to June 27, 1922.

that I last saw him alive on June 27, 1922

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

7/4, 1922 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL July 6 1922

20 UNDERTAKER Henry Storck & Son — ADDRESS 1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6564I

CERTIFICATE OF DEATH.

3 | D 6564I

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 836 W. Lombard ST.: 3 WARD)

2-FULL NAME Elizabeth Vera Morgan

(a) RESIDENCE. No. 836 W. Lombard ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L Morgan

6 DATE OF BIRTH (month, day, and year) Aug. 28th 1904

7 AGE 17 Years 10 Months 26 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NO 037

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Maik Kudirka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER E. Zebravckas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant James L. Morgan (Address) 836 W Lombard St

15 JUL 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to July 1, 1922, that I last saw h.. alive on July 1, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

July 3 1922 (Address) 2687 Westerns Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOLY REDEEMER — DATE OF BURIAL: July 5th 1922

20 UNDERTAKER: John Grebliauckas — ADDRESS: 425 S Paca St

J.G.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 65642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65642

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 N Montford Av ST.: 8 WARD)

2-FULL NAME Joseph. Broghaner

(a) RESIDENCE. NO. 1514 N. Montford av ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mary Broghaner

6 DATE OF BIRTH (month, day, and year) Mch - 4 - 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
83	83	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) — 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Connelly

(Address) 1514 N. Montford

15 Filed JUL 4 - 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to July 3, 1922, that I last saw him alive on July 2, 1922, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B O Herzog M.D. M. D.

July 3 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MD Carmel	7/5 192
20 UNDERTAKER Wm Cook	ADDRESS 502 E Nat.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65643 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 65643

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 E. Biddle ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli H. Bull

(a) RESIDENCE NO. 430 - E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lettie C. Bull

6 DATE OF BIRTH (month, day, and year) Aug-14-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68			

8 OCCUPATION OF DECEASED 030

(a) Trade, profession or particular kind of work R.R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) P.R.R Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Parkton Md

PARENTS

10 NAME OF FATHER Nicholas Bull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lettie C. Bull

(Address) 430 - E. Biddle

15 JUL 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 - 1 - 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922 to July 1, 1922

that I last saw him alive on July 1 - 1922

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Gustavus Wolfenden M. D.

July 2, 1922 (Address) 1215 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 4 1922

20 UNDERTAKER Uhlein Cook — ADDRESS 502 E North Ave

Amedori

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65644

D 65644

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3740 Gough st. ST., 26 WARD)

2-FULL NAME Nazzarena Amedori

(a) RESIDENCE NO. 3740 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vittorio Amedori

6 DATE OF BIRTH (month, day, and year) April. 6-1893

7 AGE 29 Years 2 Months 27 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Nunzio Pace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Lisabetta Vittorina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vittorio Amedori (Address) 3740 Gough st.

15 Filed 4-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922, to July 3, 1922, that I last saw h e alive on July 2, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary tuberculosis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? 622 W. Saratoga St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination of Sputum and Clinical signs

(Signed) C. Passusano, M. D.

, 19 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL George J. Ruth — DATE OF BURIAL 7/5/22

20 UNDERTAKER St Vincents Cemetery — ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65645

D 65645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 21 S Broadway ST.: V WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Agnes Cooper

(a) RESIDENCE. NO. 21 S. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March 8 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(h) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS
10 NAME OF FATHER: E O Cooper
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore
12 MAIDEN NAME OF MOTHER: Mary Bishop
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Miss Agnes Golibart
(Address) 21 S Broadway

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1922

17 I HEREBY CERTIFY, That I attended deceased from April, 1920, to July 1, 1922, that I last saw h[illegible] alive on July 1, 1922, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J J Kirby, M. D.
, 19 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: July 5 1922

20 UNDERTAKER: H. E. Hughes — ADDRESS: 4nt S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65646

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Gough ST.: V WARD)

2-FULL NAME Johanna Malanowski

(a) RESIDENCE: NO. 1722 Gough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) april 28 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Waclaw Malanowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Czajkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr Waclaw Malanowski (Address) 1722 Gough St

15 Filed JUL 4 - 1922 ROBERT R. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922 to July 3, 1922 that I last saw h alive on , 19 . and that death occurred, on the date stated above, at 4 8 m.

The CAUSE OF DEATH* was as follows:

Acute gastro Intestinal

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Congenital Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Hunter Kerby, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 5 1922

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank

Folckermer ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65647.

D 65647.

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH Baltimore and Payson Sts.

CITY OF BALTIMORE: (No. German Aged Home ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Folckermer

(a) RESIDENCE. NO. German aged Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wh	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lewisburg
(State or country) Pa.

PARENTS

10 NAME OF FATHER Jacob Folckermer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Boyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant (Address) Records German Aged Home Balto and Payson Sts.

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1917, to July 3, 1922, that I last saw h[illegible] alive on July 2, 1922, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Brain.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) J. Kelly Hemming "For Dr. Glen Hewitt"

7/3, 1922 Address) 2000 Hollins St. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lewisburg. Pa.	July 5 22

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65648

CERTIFICATE OF DEATH.

D 65648

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3408 Piedmont Ave St.; 15 Ward)

2-FULL NAME Amelia Cook

(a) RESIDENCE. No. 835 N. Fremont Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs 2 mos 28 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E Cook

6 DATE OF BIRTH (month, day, and year) Apr. 4, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George H. Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Hontz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George E. Cook
(Address) 835 N. Fremont ave

15 Filed JUL 4 - 1922 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1922, to July 2nd 1922, that I last saw h[illegible] alive on July 2nd 1922, and that death occurred, on the date stated above, at 4:40 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus + Chronic Interstitial Nephritis

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 835 N. Fremont Ave

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Lab + Physical diagnosis

(Signed) C Fulton Rowan, M. D.

(Address) 1901 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: 7/5/22

20 UNDERTAKER: Edw. Walker — ADDRESS: 1733 W Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65649

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

CERTIFICATE OF DEATH.

D 65649

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 27 WARD)

2-FULL NAME Mrs. Edward Jackson

(a) RESIDENCE. No. 501 Hawthorne Road, ST., Roland Park, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Edward Jackson

6 DATE OF BIRTH (month, day, and year) August 22nd 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Mr. John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Miss Catherine Bier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mr Holly L Jackson

(Address) 501 Hawthorn Road R.P.

15 JUL 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 19 xx, to July 3rd, 19 xx, that I last saw him alive on July 3rd, 19 xx, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma, hepatic flexure of Colon, with general metastatic Carcinosis.

(duration) 1 yrs. (?) mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of June 28th, 1922

Was there an autopsy? no

What test confirmed diagnosis? Exploratory Operation

(Signed) J. M. T. Finney, Jr., M. D.

July 3rd, 1922 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 4 1922

20 UNDERTAKER Henry H. Jenkins Sons Co. ADDRESS Edmondson Ave cor Collins

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65650

CERTIFICATE OF DEATH.

161-007

D 65650

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. E. Monument ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rosen.

(a) RESIDENCE. No. 27 N Patterson Pk Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. 7 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Detroit Mich

PARENTS

10 NAME OF FATHER Samuel Roien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Moses

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hosp Records.

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 3, 1922, that I last saw him alive on July 3, 1922, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Dystocia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

7/4, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	July 4 1922
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 6565I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 D 6565I

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Samuel Segall

(a) RESIDENCE. No. 305 W. York St. ST., WARD. Savannah, Georgia.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? unknown mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Samuel Segall

6 DATE OF BIRTH (month, day, and year) August 15th, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler 438

(b) General nature of industry, business, or establishment in which employed (or employer) Retail jewelry

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Boris Segall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Segall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mrs M Coon Savannah Ga

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30th, 1922, to July 3rd, 1922, that I last saw him alive on July 3rd, 1922, and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, splenic flexure, colon

(duration) yrs. 6 mos. (?) ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

a failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of July 1st, 1922

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) J. W. Kinnamon Jr., M. D.

July 3rd, 1922 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: SAVANNAH G-a — DATE OF BURIAL: July 4 1922

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 65652

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Park Avenue ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sheehan

(a) RESIDENCE. No. 1614 Park Avenue ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 72 yrs. -- mos. -- ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None ///

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Timothy Sheehan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Johanna Bynche

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Michael Sheehan
(Address): 1614 Park Avenue

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922 to July 3, 1922
that I last saw h[illegible] alive on July 2 1922
and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
" Uraemia
Endocarditis
Influenza
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia
(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Robert Beuck M. D.

7/3 1922 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/5. 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65653

CERTIFICATE OF DEATH.

90 D 65653

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Park Avenue ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Sheehan

(a) RESIDENCE NO. 1614 Park Avenue ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 72 yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	82	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Timothy Sheehan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johanna Bynche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael Sheehan

(Address) 1614 Park Avenue

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to July 2nd, 1922

that I last saw h alive on July 2nd 1922

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferson Busk M. D.

7/3, 1922 (Address) 2844 St James St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/5, 1922

20 UNDERTAKER Henry W. Mears & Son

ADDRESS N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

(See affadavit back)

HEALTH DEPARTMENT—CITY OF BALTIMORE

65654

CERTIFICATE OF DEATH.

31 D 65654

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 410 E. Lanvale ST., 12 WARD)

2-FULL NAME Edward Francis Collins

(a) RESIDENCE NO. 410 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Mar. 4, ~~1889~~ (1888)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34 ~~33~~	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer C. M. Kemp

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John J. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McDonal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Lillie F. Read

(Address) 410 E. Lanvale Street

15 JUL 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 2, 1922, that I last saw h[illegible] alive on July 2, 1922, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

[illegible] (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ~~1~~ yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? in Army

Did an operation precede death? --- Date of

Was there an autopsy? ---

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 3, 1922 (Address) 1038 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/5, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-002

D 65655

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 E Fort Ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Albert Niemann Jr

(Residence in Baltimore: No. 1644 E Fort Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 16th (Day), 1911 (Year)

7-AGE, ...yrs....mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Michael Albert Niemann

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER Audrey L. McIntyre

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael A Niemann

(Address) 1644 E. Fort Ave

15-

Filed JUL 4 - 1922 191.. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day), 1922 (Year).

17-I HEREBY CERTIFY, That I attended deceased from June 24 1922, to July 2 1922, that I saw him alive on July 2 1922, and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:

a Convulsions

(Duration) ....yrs....mos. 5 ds.

CONTRIBUTORY (Secondary) Postmortem Edema

(Duration) ....yrs....mos....ds.

(Signed) Henry Bloom M. D.

July 3, 1922 (Address) 1302 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Ceded Hollow	July 4, 1922

20-UNDERTAKER	ADDRESS
William Cook	502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 65656

CERTIFICATE OF DEATH

46

D 65656

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1459 Reynolds St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Mierzejewska

(Residence in Baltimore: No. 1459 Reynolds Av St.: 15 yrs. ..... mos. ..... ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: July (Month) 24 (Day), 1886 (Year)

7-AGE: 35 yrs. 11 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Poland

PARENTS

10-NAME OF FATHER: James Kirkowicz

11-BIRTHPLACE OF FATHER (State or country): Poland

12-MAIDEN NAME OF MOTHER: Mary Wojchowska

13-BIRTHPLACE OF MOTHER (State or country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Janiszewska

(Address) 1452 Linden Av

15-

Filed JUL 4- 1922 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 2 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1920 to July 2 1922, that I saw h[illegible] alive on July 1, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. 8 mos. ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos Fa Stevens M. D.

7/3, 1922 (Address) 2878 Hanford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Rosary Cem

DATE OF BURIAL: July 5, 1922

20-UNDERTAKER: Jacob Frad Sons

ADDRESS: 1450 S. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65657.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 65657.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Orleans St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Anderson

(a) RESIDENCE. No. 1732 Orleans St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic, Oto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Anderson

(Address) 1732 Orleans St.

15 Filed JUL 4 - 1922, 19.. ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1922.

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to July 1, 1922,

that I last saw h[illegible] alive on June 30, 1922,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical + Lab.

(Signed) R. J. Gosney, M. D.

, 19 (Address) 14 E. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	July 4 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Oakland Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 65658

HEALTH DEPARTMENT—CITY OF BALTIMORE D 65658

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N Madeira ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wacław Pisinger

(a) RESIDENCE. NO. 509 N. Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs mos. ds

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Pisinger

6 DATE OF BIRTH (month, day, and year) Sept 27 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	57.	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe-maker 688

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Employed

9 BIRTHPLACE (city or town) (State or country) Prizanov Bohemia,

PARENTS

10 NAME OF FATHER Wacha Pisinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Klepicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frances Pisinger
(Address) 509 N Madeira St

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2. 1922

17 I HEREBY CERTIFY, That I attended deceased from May 17th 1922, to July 2 1922, that I last saw h[illegible] alive on June 27th 1922, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver
Contributory Edema (duration) 1 yr. 6 mos. ds.

CONTRIBUTORY (Secondary) Cachexia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Stolzer, M. D.

July 5 1922 (Address) 1401 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 5 1922

20 UNDERTAKER Fred L Brack Son ADDRESS 1906 Eastern Ave

Spec.—6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65659

CERTIFICATE OF DEATH.

31 D 65659

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Linden Ave & Orleans ST.: 7 WARD)

2-FULL NAME Charles Vitale

(a) RESIDENCE. NO. 2110 E Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 10 mos. ds. How long in U. S., if of foreign birth? 31 yrs. 10 mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lina Vitale

6 DATE OF BIRTH (month, day, and year) Aug 19 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayers helper

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Vitale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Klemz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Lina Vitale
(Address) 2110 E Madison St

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12 1922, to July 2 1922 that I last saw him alive on July 2 1922 and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Peripheral Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Pending

(Signed) F. F. Sheridan M. D.

7-2-22 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 6 1922

20 UNDERTAKER Frank Overholser ADDRESS 1914 Eastlake Ave

Spec.—6-9-19—H. P. Co.— 1000 Bks.

Hirschkovitz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65660

CERTIFICATE OF DEATH.

1962 D 65660

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST.: 70 WARD)

2-FULL NAME Baby Hirschkovitz

(a) RESIDENCE. No. 2013 Eagle St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3, 1922

7 AGE: Years | Months | Days: Infant.

If LESS than 1 day, 8 hrs. or min.

8 OCCUPATION OF DECEASED: 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Samuel Hirschkovitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Rose Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Samuel Hirschkovitz

(Address): 2013 Eagle St

15 Filed JUL 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from 12 M. 7/3, 19 22, to 8 am 7/3, 19 22, that I last saw h[illegible] alive on 7/3/1922 at 3:30 PM, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dystocia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

7/3, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: July 4 1922

20 UNDERTAKER: Jack Lewis 1439 E.

ADDRESS: Balto

ROBERT R. KRAUTER

Spec.—1-10-21—M&T—1500 Bks.

Maurice Rosenthal

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 65661

CERTIFICATE OF DEATH

38

B 65661

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Maurice Rosenthal

(a) RESIDENCE NO. 1442 E. Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 38. Months ..... Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant: Bay View Hospital

(Address): Balto Md.

15 JUL 4 - 1922 ROBERT M. KRAUTHEIM Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922, to July 4, 1922, that I last saw h alive on July 3, 1922, and that death occurred, on the date stated above, at 12 15 A.M.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Depression

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Supposed in Jail

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical + Pathological

(Signed) H. Goldsmith M.D.

7/4/1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL: July 6 1922

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

15421 D 65662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 58,091 D 65662

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Luther L. Anderson

(a) RESIDENCE NO. Welch, W Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 25 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of [redacted] WIFE of Frances Anderson

6 DATE OF BIRTH (month, day, and year) Feb 4 - 1869

7 AGE: Years 53 | Months 5 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Va

PARENTS

10 NAME OF FATHER Lorenzo D. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER Rebekah Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 JUL 4 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to July 3, 1922, that I last saw him alive on July 3, 1922, and that death occurred, on the date stated above, at 5.15 P.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 7 yrs. — mos — ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) John L. Dorsey, M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Charleston W. Va. | DATE OF BURIAL July 4 1922

20 UNDERTAKER John Quitchell | ADDRESS 120 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dlubala

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65663

CERTIFICATE OF DEATH.

1001

99 D 65663

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2902 O'Donnell ST. 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dlubala

(a) RESIDENCE NO. 2902 O'Donnel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Dlubala

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Makowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Dlubala

(Address) 2902 O'Donnell St

15 JUL 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922, to July 3, 1922, that I last saw h[illegible] alive on July 3, 1922, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank A Jarmuszki M. D.

7/4, 1922 (Address) 2429 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem | DATE OF BURIAL July 5. 1922

20 UNDERTAKER Stephen F Trakowski | ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65664

CERTIFICATE OF DEATH.

179 D 65664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood. Dan. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Kemper.

(a) RESIDENCE. NO. 2428 Eutaw Place WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-18-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Aaron Kemper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rika Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) David Sandheim 115 N. Mt. Royal Ave

15 Filed JUL 4 - 1922 19.. ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from May- 24, 1921, to July - 3, 1922, that I last saw h[illegible] alive on July - 2. 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chron Interstitial Nephritis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Hoen, M. D.

7-3 1922 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai

DATE OF BURIAL 7-5- 1922

20 UNDERTAKER David Sandheim

ADDRESS 1918 W. Mt. Royal

State of Maryland }
City of Baltimore } ss:

This is to certify that on procuring copy of the birth certificate of my brother, Edward F. Collins, I found that the date of birth, as given by me to the undertaker for the official death record, was incorrect. Instead of March 4th, 1889, it should have been March 4th 1888.

In Witness Whereof I have hereunto set my hand and seal this 31st day of August, 1922.

(Mrs.) Lillie F. Read (Seal)

Subscribed & Sworn to before me this 31st day of August 1922

Lee Prince
Notary Public

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65665

HEALTH DEPARTMENT—CITY OF BALTIMORE

65665 D 65665

CERTIFICATE OF DEATH

1-PLACE OF DEATH Municipal Hospital No 4 REGISTERED NO.

CITY OF BALTIMORE: (No. 4 St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bessick

(a) RESIDENCE No. 2129 McCulloh St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1853

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

middle age

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Asst. Keeper

15 JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-1922

17 I HEREBY CERTIFY, That I attended deceased from 4-7-22, 19 . to 7-1-, 19 22

that I last saw h alive on 7-1-22, 19

and that death occurred, on the date stated above, at 3.15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/1, 19 22 (Address) Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westtown, Maryland — DATE OF BURIAL: July 5 1922

20 UNDERTAKER: Chas A. Dennis — ADDRESS 1313 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65666

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Herman Powers

(Residence in Baltimore: No. 714 Cider alley St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. March (Month) 8 (Day) 1919 (Year)

7-AGE. 3 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Wallace Powers

11-BIRTHPLACE OF FATHER, (State or Country). Texas

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mable Powers

(Address) 714 Cider alley

15- Filed JUL 5 - 1922 GG Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 1 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or]~~ Inquiry.)

thereon and from the evidence obtained by said ~~Inquest, an~~ Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) hrs. a few mins. ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(Duration) yrs. mos. ds.

(Signed) H. T. Gormley M. D. (Coroner.)

July 4 1922 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. July 5 1922

20-UNDERTAKER. Chris N Johnson ADDRESS 467 N. Carolina St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65667

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St. ..... Ward)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Henry Warnken

(Residence in Baltimore: No. no specific address Bay View Hospital St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: June (Month) 1 (Day) 1849 (Year)

7-AGE: 73 yrs. 6 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter,
(b) General nature of Industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: Luhs Warnken

11-BIRTHPLACE OF FATHER. (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER. (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred. A. Warnken

(Address) Linthicum Heights Md

15-

Filed JUL 5 - 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 3 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Multiple Burns.

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clifton Bladel M. D.
(Coroner)

July 4 192 (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cem. DATE OF BURIAL: July 5 1922

20-UNDERTAKER: Jos Joerdens Son ADDRESS 207 S. Paca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Scalded with hot coffee

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas,*	*Peritonitis.*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

D 65668

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65668

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. FRANKLIN SQUARE HOSPITAL St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ROGER BEALL PORTER

(Residence in Baltimore: No. 320-N-Pulaski-St. (20-Ward) St.; yrs. 42 mos. 10 ds. 29)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, August (Month) 3 (Day) 1879 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 10 mos. 29 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Contractor and Builder.
(b) General nature of indnstry, business, or establishment in which employed (or employer)... (self)

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Nathan Wesley Porter

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Eliza Jane Cavey

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. MaryP. Porter, (wife)

(Address) 320-N-Pulaski-St., City

15-

Filed JUL 5 - 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or Inquiry.) find that said deceased came to h.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Cribriform plat. Ethmoid Bone & Skull Cont., accident

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exudation & Brain

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R. Carlson M. D.
(Coroner.)

July 3 1922 (Address) 7 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 0 yrs. 0 mos. 1 ds. In the State 42 yrs. 10 mos. 29 ds.

Where was disease contracted, if not at place of death? Monroe and Franklin Sts. City.

Former or usual residence 320-N-Pulaski-St.

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery | DATE OF BURIAL, July-5-22 19

20-UNDERTAKER, STEWART & MOWER COMPANY (WILLIAM F. WOOD, Manager) | ADDRESS 1[illegible] N. NORTH AVE.

Is very important. See instructions on back of certificate.

D 65669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65669

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... FLORENCE MARY WEBB

(Residence in Baltimore: No. 1508-Eutaw Place. (14-Ward) St.; yrs. 27 mos. 2 ds. 1)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. May (Month) 3 (Day) 1895 (Year)

7-AGE. 27 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitoress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Mrs. Minnie Owens.

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Henry Finck

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Mary Fitzpatrick

13-BIRTHPLACE OF MOTHER. (State or Country). New York.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rich'd. E. Webb. (husband)

(Address) 1508-Eutaw Place., City.

15-

Filed ..... 192 .....

Registrar.

JUL 5 - 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 4 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiring (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Bichloride of mercury.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

July 4 192 2 (Address) 2 [illegible]

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 0 yrs. 0 mos. 12 ds. In the State 27 yrs. 2 mos. 1 ds.

Where was disease contracted, if not at place of death?.....
1508-Eutaw Place., City.

Former or usual residence. 1508-EutawPlace.

19-PLACE OF BURIAL OR REMOVAL. Baltimore County. DATE OF BURIAL. July-6- 1922

20-UNDERTAKER. STEWART & [illegible] ADDRESS 108 W. NORTH AVE.

Make CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of information is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

65670

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 65670

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St. 28th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr Mary Patricia Cummiskey

(a) RESIDENCE. No. Mt Hope Retreat St 28 Ward. Washington Ga

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? Dont Know ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Religious

(b) General nature of industry, business, or establishment in which employed (or employer) Teaching

(c) Name of employer Community

9 BIRTHPLACE (city or town) Dont Know (State or country) Dont Know

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know (State or country) Dont Know

14 Informant Rev Mother Sup (Address) Mt Hope City

Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12th 1910 to July 4th 1922, that I last saw h Sr alive on July 3rd 1922, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chr Febroid Phthisis

abt 12 or 14 (duration) yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Melancholia

abt 12 or 14 (duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington Ga

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

July 4th, 1922 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 5th 1922

20 UNDERTAKER: STEWART & MOWEN COMPANY — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 65671

D 65671

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 N. Caselt ST., 7 WARD)

2-FULL NAME Luella Anna Gotsch

(a) RESIDENCE NO. 531 N. Caselt ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, ~~or divorced~~
~~HUSBAND of~~ (or) WIFE of Frederick Gotsch

6 DATE OF BIRTH (month, day, and year) Aug 20 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Langhorst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Gotsch
(Address) 531 N. Caselt

15 Filed JUL 5 1922 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1 1920 to July 2 1922
that I last saw h[illegible] alive on July 1 1922
and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edward J Cook M. D.

7/2 1922 (Address) 4 13 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL July 5 1922

20 UNDERTAKER Wm T. Hartley ADDRESS 816 N. Washington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65672

CERTIFICATE OF DEATH.

111-002

D 65672

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. McLaughlin

(a) RESIDENCE. No. 1821 W. Pratt ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Julia McLaughlin

6 DATE OF BIRTH (month, day, and year) 1849 -

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Industrial

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Joseph McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Mary Dayly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Wife 1821 W Pratt St.

15 JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to July 4, 1922, that I last saw h[illegible] alive on July 4, 1922, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

1 ..... (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diffuse peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 2, 1922

Was there an autopsy? No -

What test confirmed diagnosis? Operation

(Signed) J. Willis Guyton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	7-6- 1922
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Oakham Hollins st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65673

CERTIFICATE OF DEATH.

179 D 65673

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 N. Dallas ST., 7 WARD)

2-FULL NAME Sophia Shramek

(a) RESIDENCE. No. 937 N. Dallas ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Shramek

6 DATE OF BIRTH (month, day, and year) Feb. 8-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

937

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Thos. Ryba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Charles Shramek
(Address) 937 N Dallas St

15 Filed JUL 5 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 - 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to July 2, 1922, that I last saw her alive on " 1, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Test of urine

(Signed) Edwin B. Fenby, M. D.

7/31/1922 (Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cem.

DATE OF BURIAL July 5th 1922

20 UNDERTAKER Geo. M. Fink & Son, Funeral Directors & Embalmers.

ADDRESS 811 Norfolk

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65674

CERTIFICATE OF DEATH.

D 65674

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 116 N. Rose ST.; 6 WARD)

2-FULL NAME Sallie A. Pitts

(a) RESIDENCE. NO. 116 N. Rose ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Pitts

6 DATE OF BIRTH (month, day, and year) April 3/1881

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Louis Pitts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Julia Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Mrs. Carrie Pitts
(Address) 116 N. Rose St.

15 Filed JUL 5 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1922

17 I HEREBY CERTIFY, That I attended deceased from about May 1st, 1922, to about middle July 22, that I last saw h[illegible] alive on about middle June, 1922, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Penis.

(duration) about 5 months yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) Rud Locher, M. D.

19 (Address) 31 E. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	July 5 1922

20 UNDERTAKER Jos. J. Iden ADDRESS 156 N. Luzerne ave

mation should be carefully supplied. AGE should be stated EXACTLY. PRECISE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65675

CERTIFICATE OF DEATH.

113

D 65675

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 102 W. Hill St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles L. Harris.

(Residence in Baltimore: No. 102 W. Hill St. St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. May 3rd. 1922. (Month) (Day) (Year)

7-AGE. ds. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Marvin L. Harris.

11-BIRTHPLACE OF FATHER, (State or Country). New Jersey.

12-MAIDEN NAME OF MOTHER. Bertha M. Clough.

13-BIRTHPLACE OF MOTHER, (State or Country). Chester, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha M. Harris. (mother)

(Address) 102 W. Hill St.

15- Filed JUL 5 - 1922 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3rd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

July 4th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Cemd. Dc. DATE OF BURIAL. July 6 192?

20-UNDERTAKER. Fred. A. Francis & Son ADDRESS 703 Hanover St

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65676 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 936 Franklin St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Smith

(Residence in Baltimore: No. 936 Franklin St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Jan (Month) 4 (Day) 1852 (Year)

7-AGE: 70 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Charles Smith

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Troxel

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Goldie E. Higgins

(Address) 936 Franklin Park

15-

Filed JUL 5 - 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 3 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Hemmeter M. D.
(Coroner.)

July 4 1922 (Address) 202 Courtland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Ridge Cemetery DATE OF BURIAL: July 5 1922

20-UNDERTAKER: William Cook ADDRESS 502 E Nott

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

10091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65677

CERTIFICATE OF DEATH.

45D 65677

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Park Heights and Glen Ave) (STREET) (WARD)

2-FULL NAME Augusta Kirkwood.

(a) RESIDENCE No. Park Heights and Glen Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations or symbols must not be used.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Wm. Kirkwood.

6 DATE OF BIRTH (month, day, and year): Aug 22/1861.

7 AGE — Years: 60 years. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm. Kirkwood.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: dont know -

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Wm. Kirkwood Park Heights and Glen Ave

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3/ 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to July 3, 1922, that I last saw h[illegible] alive on July 3, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Anemia Pernicious + Cachexia (duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? Yes at Home

Did an operation precede death? Yes Date of June 8

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) W D Wells, M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet. DATE OF BURIAL: July 6/ 1922

20 UNDERTAKER: Wm. Cook ADDRESS: 502 E North ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65678

CERTIFICATE OF DEATH.

129 D 65678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 43 S. Arlington Ave. St., 18 WARD)

2-FULL NAME Charles H. Ballard,

(a) RESIDENCE NO. 43 S. Arlington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Ballard.

6 DATE OF BIRTH (month, day, and year) Dec 21, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber. 059

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing.

(c) Name of employer None.

9 BIRTHPLACE (city or town) Balto, (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Ballard.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Mabb.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Josephine Ballard. (Address) 43 S. Arlington Ave

15 Filed JUL 5 - 1922 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1922 to July 4, 1922 that I last saw him alive on July 4th, 1922 and that death occurred, on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J. Thos. Norton, M. D.

7/14/22 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem DATE OF BURIAL July 7. 1922

20 UNDERTAKER William Cook. ADDRESS 507 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65679 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65679

CERTIFICATE OF DEATH.

Registered No. C 182

1-PLACE OF DEATH. City of BALTIMORE Broadway Pier Bray & Thames St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Suarez.

(Residence in Baltimore: No. 1635 Thames St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Feb. (Month) 11 (Day) 1916 (Year)

7-AGE. 6 yrs. 4 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Jose Suarez

11-BIRTHPLACE OF FATHER. (State or Country). Spain

12-MAIDEN NAME OF MOTHER. Aurelia Mace

13-BIRTHPLACE OF MOTHER. (State or Country). Spain

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jose Suarez

(Address) 1635 Thames St

15- Filed JUL 5 - 1922 192 J. H. Helm Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 3 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. ds.

(Signed) Geo. Talbot Bladen M. D. (Coroner.)

July 4 192 (Address) 143 N. Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mount Lamelbe DATE OF BURIAL. July 5. 1922

20-UNDERTAKER. H. Sander Sons ADDRESS 1710 Fleet St.

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 65680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 ✓ D 65680

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1106 Calhoun st ST., 18 16 WARD)

2-FULL NAME Constance Thompkins

(a) RESIDENCE NO. 1106 Calhoun st ST., 18 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James Thompkins

11 BIRTHPLACE OF FATHER (city or town) Edgefield
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Katie Jurgerson

13 BIRTHPLACE OF MOTHER (city or town) Spartanburg
(State or country) South Carolina

14 Informant Father James Thompkins
(Address) 110 e. Calhoun st

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to July 4, 1922, that I last saw her alive on July 4, 1922, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) Frank Saunders, M. D.

7-5, 1922 (Address) 1123 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 7-6-1922

20 UNDERTAKER Sam'l N. Chase & Son — ADDRESS 1400 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT CITY OF BALTIMORE

(Levin)

D 65681

137

D 65681

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Helen Wright ST.: 17 WARD)

2-FULL NAME Anna Sol Levin

(a) RESIDENCE. No. 1017 Lemmon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 26 yrs. 3 mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sol Levin

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Labarinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Rosenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to July 4, 1922, that I last saw her alive on July 4, 1922, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Papillomatous Cyst of Ovary with metastases (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No test

(Signed) Ernest Edelmann, M. D.

7/4, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship July 5 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65682

CERTIFICATE OF DEATH.

D 65682

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 18 N. Edmond Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Jennie N. Hannan

(Residence in Baltimore: No. 18 N. Edmond Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Sept (Month) 21 (Day) 1855 (Year)

7-AGE. 66 yrs. 9 mos. 12 ds. If LESS than 1 day. ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 004
(b) General nature of industry, business, or establishment in which employed (or employer): Rolling Co

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Geo Hannan

11-BIRTHPLACE OF FATHER. (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Frank Mallon

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Hannan

(Address) 18 N. Edmondson

15-

Filed JUL 5 - 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 3 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Wilkes M. D.
(Coroner.)

7-4 1922 (Address) 5 N. E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cemetery	7/6 1922
20-UNDERTAKER Wayland	ADDRESS 3000 E. Baltoff
J. A. Moran	

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65683

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 111 Montebello Terrace ST., 27 WARD)

2-FULL NAME Anna Schiller.

(a) RESIDENCE NO. 111 Montebello Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20th 55

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Heine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Schiller
(Address) 111 Montebello Terr

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3d 1922

17 I HEREBY CERTIFY, That I attended deceased from May 14. 1922 to July 3d 1922
that I last saw her alive on July 3d 1922
and that death occurred, on the date stated above, at 6 40 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Strangulated Ht. Femoral Hernia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray —

(Signed) Charles Bagley, Jr. M. D.

19 (Address) Lafayette Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 7/5 1922

20 UNDERTAKER John A Moran

ADDRESS 300 E Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65684
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

179 D 65684
Registered No. C.....

City of BALTIMORE: (No. 1714 McCulloh St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sarah Cooper

(Residence in Baltimore: No. 1714 McCulloh St.; yrs. 50 mos. ds.)

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Negro

5-Single, Married, Widowed, or Divorced (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1..... (Year)

7-AGE. 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundress
(b) General nature of industry, business, or establishment in which employed (or employer). 041

9-BIRTHPLACE, (State or Country). Cambridge Md

PARENTS.

10-NAME OF FATHER. Bradford Chester

11-BIRTHPLACE OF FATHER, (State or Country). Cambridge Md

12-MAIDEN NAME OF MOTHER. Sarah Eliz

13-BIRTHPLACE OF MOTHER, (State or Country). Cambridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stepdaughter

(Address) 1714 McCulloh

15-

Filed JUL 5 - 1922 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day), 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hollis M. D.
(Coroner)

7-5 192.2 (Address) 1.C.E. Entrance

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Albany — DATE OF BURIAL, July 5, 1922

20-UNDERTAKER, John W. Henderson — ADDRESS 502 Eastern

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65685

179 D 65685

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1616 N Durham St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ida E. Reinhardt

(Residence in Baltimore: No. 1616 N Durham St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (If married or widowed, write the word.): Single

6-DATE OF BIRTH: June 21 (Month) (Day) 1921 (Year)

7-AGE. 1 yrs. 13 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: George T Reinhardt

11-BIRTHPLACE OF FATHER. (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Mary J Riegelman

13-BIRTHPLACE OF MOTHER. (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mr George T Reinhardt

(Address): 1616 N Durham St

15- FILED JUL 5 - 1922 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 4 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Burns. accident.

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Forceps

(Duration) yrs. mos. ds.

(Signed) Geo. Clinton Blades M. D.
(Coroner)

July 11 1922 (Address) 1423 N. Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL. July 5 1922

20-UNDERTAKER. Henry Hoeck & Son ADDRESS 1301 E Eager St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Boys smoking in yard. Mosquito netting on child caught fire.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas.*	*Peritonitis.*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 65686

HEALTH DEPARTMENT—CITY OF BALTIMORE

65686

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., (WARD)

2-FULL NAME Mrs. Eliz. Shaad

(a) RESIDENCE NO. 885 N. Howard St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam. Shaad

6 DATE OF BIRTH (month, day, and year) —— 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H'wife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mrs. Sam. Shaad (Address) 885 N. Howard St

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24 1922 to July 4 1922

that I last saw her alive on July 4 1922

and that death occurred, on the date stated above, at 7:00 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast with General metastasis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure following toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) A. L. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	July 5 1922
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	Pk Greenmt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65687

D 65687

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4233 York Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Edward Heavel

(a) RESIDENCE. NO. 4233 York Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie E. Heavel

6 DATE OF BIRTH (month, day, and year) April 27-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Light Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Zacharia Heavel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Caroline Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

11 Informant Mollie E. Heavel

(Address) 4233 Greenmount Ave

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to July 3, 1922, that I last saw him alive on July 3, 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

10 hours

(duration)

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. D. Steenken, M. D.

, 19 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 5 1922

20 UNDERTAKER H. C. Wiedefeld 914 ADDRESS Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65688

CERTIFICATE OF DEATH.

38 D 65688

REGISTERED NO.

1-PLACE OF DEATH St. V. de P.

CITY OF BALTIMORE (No. 1704 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph James Norris

(a) RESIDENCE NO. 1704 Division ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed~~ or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov. 1. 1919

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant St. Vincent de Paul's (Address) 701 Division

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3. 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 3, 1922, that I last saw him alive on July 1, 1922 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None —

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical Signs

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: July 5 1922

20 UNDERTAKER: Martin Tuley Sons ADDRESS: 1822 N North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65689

CERTIFICATE OF DEATH.

49

D 65689

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 North Collington Ave 46 ST.; WARD)

2-FULL NAME Henry Botkoff

(a) RESIDENCE. No..... ST., WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14
Informant .....
(Address)

JUL 5 1922 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17
I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....,
that I last saw h.....alive on....., 19.....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 7 1922
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1734 Eager

D 65690

Dec.—6-9-19—H. P. Co.—1000 Bks.

D 65690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Old Pimlico Road near

CITY OF BALTIMORE (No. Steele Road Mt. Washington ST.; 27 WARD)

2-FULL NAME Clara A. Keanes

(a) RESIDENCE. NO. Mt. Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 18-1902

7 AGE: Years 20 Months 5 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos A. Keanes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Roche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos A. Keanes

(Address) Mt. Washington

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4" 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1918 to July 4 1922

that I last saw h[illegible] alive on July 4 1922

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) R. P. Hardesty, M. D.

19 (Address) 1111 E. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: July 6" 1922

20 UNDERTAKER: Chas F. Evans & Son

ADDRESS: 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Bena

D 6569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6569

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Rizzo Ave 46 ST.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalie Bena

(Residence in Baltimore: No. 2912 Rizzo Ave St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Nov 1st, 1828 (Month) (Day) (Year)

7-AGE, 93 yrs. 8 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Work

9-BIRTHPLACE, (State or Country), Lorraine, France

PARENTS.

10-NAME OF FATHER, Christopher Jaxel

11-BIRTHPLACE OF FATHER (State or Country), Lorraine France

12-MAIDEN NAME OF MOTHER Catherine Durand

13-BIRTHPLACE OF MOTHER (State or Country), Lorraine France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosalie B. Belz

(Address) 2912 Rizzo Ave

15- JUL 5 - 1922

Filed....., 191.....

H. Anne

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to July 3 1922; that I saw her alive on July 3 1922, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Cerebral Embolism with Cerebral Hemorrhage Interstitial nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. ds.

(Signed) John C. Hubard M. D.

July 4, 1922 (Address) 1219 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, July 6, 1922

20-UNDERTAKER B L Hopkins

ADDRESS Annapolis Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65692

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65692

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3307 Paine ST., 13 WARD)

2-FULL NAME Sarah J. Davis

(a) RESIDENCE NO. 3307 Paine ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of: Robert Davis

6 DATE OF BIRTH (month, day, and year): Sept 25/1850

7 AGE — Years: 71 — Months: 9. — Days: 8 — If LESS than 1 day, ...hrs. or.... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city Md.

PARENTS

10 NAME OF FATHER: John Slattery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Isabella Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto city Md

14 Informant: Walter Davis

(Address) 3307 Paine St

Filed JUL 5 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3. 1922

17 I HEREBY CERTIFY, That I attended deceased from See Remarks, 19.., 19.., that I last saw h.. alive on .., 19.., and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Cancer of vulva

for years.

Dr. [illegible] Mortuary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R B Norment M. D.

7/3. 1922 (Address) 3543 Chestnut ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 7/6 1922

20 UNDERTAKER: Townsend & Son — ADDRESS: 3617 Chestnut ave.

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dorothy Staszowski V

D 65693

Spec. 6-9-1[illegible] 000 Bks.

D 65693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 114

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2207 Essex ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Staszowski

(a) RESIDENCE. NO. 2207 Essex ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 29/20

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	2	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Staszowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Elizabeth Nowakowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Joseph Staszowski.
(Address) 2207 Essex St

15 Filed JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 - 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1922, to July 3, 1922; that I last saw h[illegible] alive on July 2, 1922, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1922 (Address) 422 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL July 5. 1922

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Caro

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65694

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) (St.) (WARD 26)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Municipal Tuberculosis Hospital

2-FULL NAME James Wise

(a) RESIDENCE. NO. None ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Louis Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

15 JUL 5 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to July 1, 1922, that I last saw him alive on July 1, 1922, and that death occurred, on the date stated above, 10.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Howard L. Dadaylacca M. D.

7-2-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington Junction	July 5 1922

20 UNDERTAKER Frederick Co. ADDRESS 142 Aisquith St

John H. Bradman

INSTRUCTIONS. Answer all questions fully. Where the word "none" should be used, write it. Where the answer is unknown or doubtful, state the best information obtainable. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65695 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65695

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1550 Argyle Av ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A. Bell

(a) RESIDENCE. NO. 1550 Argyle Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Bell

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Cordray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph Bell (Address) 1550 Argyle Ave

15 Filed JUL 5 - 1922 W. Lane Registrar,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 3, 1922, that I last saw h[illegible] alive on July 3, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no Clinical

What test confirmed diagnosis?

(Signed) A B Huggins M. D.

July 5, 1922 (Address) 1413 S. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL 7/5 1922

20 UNDERTAKER David T. Chandler ADDRESS 5 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65696

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 65696

91 REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 531 E 23rd ST.: 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Katherine Kiely

(Residence in Baltimore: No. 531 E 23d St.: 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May (Month) 11 (Day), 1850 (Year)

7 AGE: 72 yrs. 1 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Cook

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Daniel Kiely

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Dooley

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Minnie Shirley

(Address) 531 E 23d St

15 JUL 5 - 1922, 191 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 3 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to. June 3 1922
that I saw h[illegible] alive on July 2, 1922
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows: 1

Arteriosclerosis

(Duration) 1 yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Feeton M. D.

July 4 1922 (Address) 700 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New Cathedral DATE OF BURIAL: July 7 1922

UNDERTAKER: E A Widefield ADDRESS: 501 E 22 St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Intracranial hemorrhage

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of_____(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train — accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65697

CERTIFICATE OF DEATH

REGISTERED NO. 159

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Howard & Linden Ave ST.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Wallis

(a) RESIDENCE. NO. 22 Church ST., Centre Bay. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., If of foreign birth? Life yrs. — mos. — ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Wallis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Olek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Peter Wallis
(Address) 22 Church Ste

15 JUL 5 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 4, 1922, that I last saw h in alive on July 4, 1922, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Meningocele

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of June 29-22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Hulet Wilkerson M. D.

, 19 (Address) Maryland Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	July 5 1922
20 UNDERTAKER Stephen J Fialkowski	ADDRESS 1001 Hanover

Spec.—1-10-21—M&T—1500 Mss.

D 65698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65698

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Municipal Hospital

CITY OF BALTIMORE: (No.) Mathias (St.,) Neumann (Ward)

2-FULL NAME

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 70 (Years / Months / Days)

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Harry Lee

15 Filed JUL 5 - 1922 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/28/1922

17 I HEREBY CERTIFY, That I attended deceased from 11-7-18 to 6/28/1922

that I last saw him alive on 6/28/1922

and that death occurred, on the date stated above at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

7/1, 1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: NL — DATE OF BURIAL 1922

20 UNDERTAKER — ADDRESS

Commissioner Health.

Instructions should be carefully followed. Avoid use of abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—[illegible]

D 65699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65699

CERTIFICATE OF DEATH.

REGISTERED NO. 122-002

1-PLACE OF DEATH Municipal Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) [illegible] ST., 3 WARD)

2-FULL NAME Robert Hackett

(a) RESIDENCE NO. 503 Eastern Ave ST., [illegible] WARD [illegible]
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? [illegible] yrs. [illegible] mos. [illegible] ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hosp. Records

15 Filed JUL 5 - 1922 ROBERT A. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/7/1922 to 6/27/1922
that I last saw him alive on 6/27/1922
and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver

(duration) yrs. mos. 2 1/2 ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Clyde M. O'Neil, M. D.
7/1/1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL JUL 1 1922

20 UNDERTAKER [illegible] ADDRESS [illegible]

Commissioner Health.

220

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65700 (C) D 65700

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery and Childs Hospital, 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Scott

(a) RESIDENCE. NO. 2631 N.Calvert ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov.4,1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	0	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Romie Scott. (dead)

11 BIRTHPLACE OF FATHER (city or town) Chestertown (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Addie Kelley

13 BIRTHPLACE OF MOTHER (city or town) Rock Hall (State or country) Maryland.

14 Informant

(Address)

15 Filed JUL 5 - 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30,1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922. to June 30. 1922. that I last saw him alive on June 30. 1922., and that death occurred, on the date stated above, at 12.17A. m.

The CAUSE OF DEATH* was as follows:

Acute Entero-colitis

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Mal J Heinglein M. D.

19 (Address) 1007 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL July 1 1922

20 UNDERTAKER

ADDRESS

Commissioner Health.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65701

HEALTH DEPARTMENT—CITY OF BALTIMORE

Pac

16K

D 65701

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1744 Fleet ST.; V WARD)

2-FULL NAME John Pac

(a) RESIDENCE NO. 1744 Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 4 22

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Pete Pac

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Katie Zyhodak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mother Pac

(Address) 1744 Fleet

15 Filed JUL 5 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1922, to July 5, 1922

that I last saw ... alive on July 5, 1922

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Acute Sepsis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wilson Powers M. D.

July 5 1922 (Address) 817 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: July 6 1922

20 UNDERTAKER: John M Weber

ADDRESS: 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65702 — 100-091 — D 65702

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Municipal Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (a) NO..... ST.:..... WARD)

2-FULL NAME James Merritt

(a) RESIDENCE. NO..... ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	W

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital
(Address)

15 Filed JUL 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/1922

17 I HEREBY CERTIFY, That I attended deceased from 6-4-1922, to 6/30/1922

that I last saw him alive on 6/30/1922

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile deterioration

(duration) 7 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

7/1, 1922 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	July 5 1922
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

219

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65703

CERTIFICATE OF DEATH.

78 D 65703

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., N WARD)

2-FULL NAME Mollie Chandler

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook (21)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bay View Hospital (Address) Balto, Md.

15 Filed JUL 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1913 to June 29, 1922

that I last saw h alive on June 29, 1922

and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Epileptic Psychosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) H. Holsworth, M. D.

7/3/1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL July 5 - 1922

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

219

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65704

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH D 65704

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Wallace

(a) RESIDENCE. NO. 832 Tessier st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Elliot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise Merridith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M. T. H.

15 Filed JUL 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to July 2, 1922, that I last saw her alive on July 2, 1922, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Padgett M. D.

7-3-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL July 5 1922

20 UNDERTAKER Commissioner Health.

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 65705 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 65705

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital Ward C

CITY OF BALTIMORE: (No. ... ST. No WARD)

REGISTERED NO. ...
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Smith

(a) RESIDENCE NO. ... ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE: Years 60 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 870
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (city or town) (State or country) ?
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant ...
(Address) UNIVERSITY OF MARYLAND.

15 Filed JUL 5 - 1922, 19 ... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 22 to July 2, 19 22
that I last saw h[illegible] alive on July 2, 19 22,
and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Uterine fibroids + generalized adeno-sclerosis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? ...

What test confirmed diagnosis? Physical Exam

(Signed) J. Richard Jones M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: July 5 19 22

DATE OF BURIAL

20 UNDERTAKER: Commissioner Health.

ADDRESS

[illegible] MARSHALL

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D 65706

REGISTERED NO. D 65706

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 S. 13th St. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. S. Baier.

(a) RESIDENCE NO. 624 S. 13th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None yrs

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Baier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Alice Stewart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Los Angeles. Cal.

14 Informant Frederick Baier. (Address) 624 S. 13th St.

15 Filed JUL 5 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to July 4, 1922, that I last saw her alive on July 4, 1922, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Congestion
due to diffused brain

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Open Foramen Ovale

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton M. D.

7/5, 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL July 7 1922

20 UNDERTAKER Lilly and Zeile

ADDRESS 4038 Wolfe St.

Matter should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65707

CERTIFICATE OF DEATH.

31 D 65707

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 N. Central Ave ST., 10 WARD)

2-FULL NAME Helen Virginia Young

(a) RESIDENCE NO. 719 N Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colard

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 10, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~917~~	5	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto city

(State or country)

PARENTS

10 NAME OF FATHER James P. Young

11 BIRTHPLACE OF FATHER (city or town) [illegible]

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Helen Bell

13 BIRTHPLACE OF MOTHER (city or ~~town~~) Balto

(State or country)

14 Informant (Address) James P Young 719 n Central Ave

15 Filed JUL 5 - 1922 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3-1922

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1922 to July 3 1922 that I last saw her alive on July 3 — 1922 and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis of Lungs

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

Bronchitis (duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

7-5. 1922 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: July 6 1922

20 UNDERTAKER: Robert V. Millikin — ADDRESS: 706 Ashland ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 65708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 W. Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johannah Weichmann

(a) RESIDENCE. NO. 526 W. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 6, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calbe Germany

PARENTS

10 NAME OF FATHER: Karl Friederick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baalam Germany

12 MAIDEN NAME OF MOTHER: Johannah Harkbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calba Germany

14 Informant (Address): Wilhelmina Hobert 526 W. Saratoga

15 Filed JUL 5 - 1922 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1922, to July 5th, 1922

that I last saw her alive on July 5th, 1922

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Duration first Feb 2 1922

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) R. B. Evans, M. D.

19 (Address) 411 N Greene St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Jul 7 1922

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 2173 Ba

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65709

REGISTERED NO. 117 D 65709

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hosp ST., 70 WARD)

2-FULL NAME Henry Schmidt

(a) RESIDENCE NO. 2 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adolph Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mamie D. Starke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Adolph Schmidt 15 N. Bentalou st

15 Filed JUL 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1922 to July 3, 1922 that I last saw him alive on July 3, 1922 and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH* was as follows:

General Peritonitis (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of July 3, 22

Was there an autopsy? no

What test confirmed diagnosis? Laparotomy

(Signed) J A Schmeisch, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 6 1922
20 UNDERTAKER	ADDRESS, 1039
E Schloman & Son	Hanover st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated [illegible]

Spec.—1-10-21—M&T—1500 Bks.

Cazer Chisolm

D 65710 HEALTH DEPARTMENT—CITY OF BALTIMORE

5 | D 65710

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1408 McCulloh ST., 14 WARD)

2-FULL NAME Cazer Chisolm

(a) RESIDENCE NO. 1408 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Carrie Chisolm

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) — 040

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Benjamin McCulloh
(Address) 1408 McCulloh

15 Filed JUL 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922 to July 4, 1922
that I last saw h.. alive on July 4, 1922
and that death occurred, on the date stated above, at 6:45 p.m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) yrs. about mos. 15 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Chisolm, M. D.
, 19 (Address) 1134 - 20 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. — DATE OF BURIAL 7/5 1922

20 UNDERTAKER George T. A. Gibson — ADDRESS 513 [illegible] St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901

D 65711

CERTIFICATE OF DEATH.

D 65711

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N. Central Ave ST., 5 WARD)

2-FULL NAME Mattie Bacon

(a) RESIDENCE No. 613 N. Central Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) April 5-1920

7 AGE 2 Years 3 Months — Days 18 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Arthur Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bessie O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Baltimore

14 Informant (Address) Mother Bessie Bacon 613 N Central Ave

15 JUL 6-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30. 1922 to July 4. 1922.

that I last saw her alive on July 3 - 1922

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... No Date of .....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Dr. G. W. Kennard M. D.

7-5. 1922 (Address) 708 Ensor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem DATE OF BURIAL July 7 1922

20 UNDERTAKER Irvin Robert A Elliott ADDRESS 1725 Oakland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"): *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65712

CERTIFICATE OF DEATH.

31

D 65712

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 East ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Cook

(a) RESIDENCE. No. 220 East ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Frazier Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Cyrus Gibson

(Address) 220 East-St

15 Filed JUL 6 - 1922 19 G G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 3, 1922

that I last saw him alive on July 3, 1922

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (Chron

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

7/5, 1922 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	July 6 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1720 Ashland Av

Spec.—1-10-21—M&T—1500 Bks.

D 65713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65713

1-PLACE OF DEATH St. Joseph's Hospital

REGISTERED NO. 9 X 29

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Fridel (Friedel)

(a) RESIDENCE NO. Mace Ave, near Nicholson Ave, Govanstown ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attended school.

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Fridel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Krause

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John Fridel

(Address) Mace Ave near Nicholson Ave

15 Filed JUL 6 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1922

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1922 to July 4, 1922

that I last saw him alive on July 4, 1922

and that death occurred, on the date stated above, at 9.35 p m.

The CAUSE OF DEATH* was as follows:

Primary: Myocardial Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tetanus

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S W Kramer, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL July 8 1922

20 UNDERTAKER Lilly and Fuller ADDRESS 403 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PERSONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1140 D 65714

REGISTERED NO.

D 65714 CERTIFICATE OF DEATH

CITY OF BALTIMORE: (No. 612 archer ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley E. Price

(a) RESIDENCE NO. 612 archer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — 1919

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER John Price

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Lucy Wright

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant John Price (Address) 612 archer st

15 Filed JUL 6 - 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1922, to July 4th, 1922, that I last saw him alive on July 4th, 1922, and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D H Carroll M. D.

July 6, 1922 (Address) 140 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL July 6 1922

20 UNDERTAKER John H. Toadvine — ADDRESS 142 W Lexington St

mation should be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE YEAR, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1563 99

D 65715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111 001

D 65715

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 18 WARD)

2-FULL NAME Millie Broaden.

(a) RESIDENCE NO. 229 Arlington Ave City WARD 5

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Sallie adams

6 DATE OF BIRTH (month, day, and year): March 25 1875

7 AGE: 47 Years | 3 Months | 10 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jerry Dale.

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ?

12 MAIDEN NAME OF MOTHER: Adelaide Keys

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? ?

14 Informant: JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed JUL 6 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 16th 1922, to July 5 1922

that I last saw her alive on July 5 1922;

and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 19, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J B Mac Cready, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: July 8 1922

20 UNDERTAKER: John F Toadvine

ADDRESS 142 Uthice St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65716

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 Orleans ST., 6 WARD)

2-FULL NAME Wilhelmenia Winkler

(a) RESIDENCE No. 1839 Orleans ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Winkler

6 DATE OF BIRTH (month, day, and year): June 8-1850

7 AGE: Years 72 — Months — Days 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Karl Greve

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophie Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sophie Winkler Wife

(Address): 1839 Orleans St.

Filed JUL 6 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-18, 1922 to July 3, 1922, that I last saw her alive on July 3, 1922, and that death occurred, on the date stated above, at 9:12 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Heart Exhaustion
Arteriosclerosis (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ooo

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Frank Ruth M. D.

July 7, 1922 (Address) 900 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mathews Cem

DATE OF BURIAL: July 6 1922

20 UNDERTAKER: John Ullrich

ADDRESS: 2005 Orleans

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by law to report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65717

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65717

CERTIFICATE OF DEATH.

114

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 856 Columbia Av ST., 21 WARD)

2-FULL NAME Mrs. H. Y. Miller

(a) RESIDENCE NO. 856 Columbia Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 5 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Jno F Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Ruby Yount

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant John F. Miller

(Address) 856 Columbia Av

15 JUL 6 1922. 19 W. A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1922, to July 5, 1922, that I last saw h— alive on July 5, 1922, and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ..... yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia Intoxication

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Richard Dean, M. D.

, 19 (Address) 856 Columbia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL July 7 1922

20 UNDERTAKER John J. Feldmann — ADDRESS 1200 N. Fremont

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65718

D 65718

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 3508 Elm Ave (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Kemp

(a) RESIDENCE. NO. 3508 Elm Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Alice M Kemp

6 DATE OF BIRTH (month, day, and year) Sept 22 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER William H. Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Harriet Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Mrs Alice M. Kemp (Address) 3508 Elm Ave

15 Filed JUL 6 - 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1918, to July 4 1922, that I last saw h alive on July 4 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What (test confirmed diagnosis? Symptoms Duration

(Signed) Evan T Kemp M. D.

7/5, 19 22 (Address) 3705 Talbot Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL July 6 19 22

20 UNDERTAKER H S Marshall ADDRESS 3589 Falls Rd

Blanks should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65719 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65719

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman M. North

(a) RESIDENCE NO. 3024 Edmondson Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 11/66

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
56	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Elevator Operator

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Robt. North

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emily J. — 1/5/

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hy. Record

(Address)

15 Filed JUL 6 1922, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/4/1922

17 I HEREBY CERTIFY, That I attended deceased from 7/2, 1922, to 7/4, 1922, that I last saw h alive on 7/4, 1922, and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Septicaemia from infected tar

(Duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cerebrospinal syphilis (duration) 5 yrs. mos. ds.

If Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

(Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 7/6 1922

20 UNDERTAKER: Philip Herwig

ADDRESS 2014 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65720 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65720

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56, REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY, MD. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. SANDERSON,

(a) RESIDENCE No C/O Y.M.C.A. 3rd St., New York ST. N.Y. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address)

15 Filed JUL 6 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1922, to July 2, 1922,

that I last saw him alive on July 2, 1922,

and that death occurred, on the date stated above, at 5:35 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis, Moderately Advanced & Active.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

7/3/22 (Signed) [illegible] M. D.

(Address) Fort McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery DATE OF BURIAL July 6, 1922

20 UNDERTAKER S. Guinan & Bro ADDRESS 1127 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 65721 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65721

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH U.S.VETERANS' HOSPITAL#56-

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Blackwell

(a) RESIDENCE NO. 241 W.Preston St.Baltimore,Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of Mrs.Thomas Blackwell

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Driver

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant HOSPITAL RECORDS

(Address) Ft.McHenry,Md.

15 Filed JUL 6 - 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov.7, 1921, to July 3, 1922, that I last saw him alive on July 3, 1922, and that death occurred, on the date stated above, at 8:35 p m.

The CAUSE OF DEATH* was as follows:

Tubercular Ulcer Urinary Bladder

" Ruptured Bladder"

-

-- (duration) - yrs. - mos ds.

CONTRIBUTORY (Secondary) Chronic Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes July 3,1922

What test confirmed diagnosis? Clinic.& Lab.Reports

(Signed) H.B.Lusk, M. D.

SURGEON (R)

7/13/22 Address U.S.V.HOSP.#56,Ft.McHenry,Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL July 6 1922

20 UNDERTAKER L.Lusser & Bro ADDRESS 417 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 165722 (1615) 165722 D 165722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. D 165722

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME George Slocum

(a) RESIDENCE NO. 404 Diamond St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) June 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Albert Slocum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Roland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to July 5, 1922; that I last saw h[illegible] alive on July 5, 1922, and that death occurred, on the date stated above, at 10 30 p.m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) ..... yrs. ..... mos 22 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Horace G. Stewart, M. D.

7/6, 19 22 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL July 8 1922

20 UNDERTAKER R. B. Gross, 1405 McElderry — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65723

CERTIFICATE OF DEATH.

REGISTERED NO. 139

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1450 Boyle ST. 24th WARD)

2-FULL NAME Sarah J. Caswell.

(a) RESIDENCE. No. 1450 Boyle. ST. 24th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Louis Caswell

6 DATE OF BIRTH (month, day, and year) not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER James Hubbard.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant Mrs Drucilla Rebstock

(Address) 1450 Boyle St.

15 Filed JUL 6 1922. 19 H. A. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27 1922, to July 3 1922, that I last saw her alive on July 3 1922, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Streett, M. D.

7/5, 1922 (Address) 1405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 7-6 1922

20 UNDERTAKER: E and B Harle — ADDRESS 115 E Heath

Information should be carefully supplied. ALL should be stated EXACTLY. The OCCUPATION should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 65724

D 65724 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 Cumberland ST., 15 WARD)

2-FULL NAME John Casper Sauter

(a) RESIDENCE NO. 734 Cumberland ST., 15 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Sauter

6 DATE OF BIRTH (month, day, and year) Mar 28 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hoffenweiler Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) Hoffenweiler (State or country) Germany

14 Informant John Mayer

(Address) 734 Cumberland St

15 Filed JUL 6 - 1922 19 ..... A. Law. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to July 5, 1922, that I last saw him alive on July 5, 1922 and that death occurred, on the date stated above, at 2.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Carl Lauman, M. D.

, 19 (Address) 1801 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL July 6 1922

20 UNDERTAKER William Cook ADDRESS 1026 E North Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65725 D 65725

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. North Pt 225 S Chapel ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Novak

(a) RESIDENCE. NO. North Point Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	[redacted]	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Back road

PARENTS

10 NAME OF FATHER Michael Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ella Laskowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburg Penn

14 Informant Michael Novak (Address) Back Point Road

15 Filed JUL 8 - 1922 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 - 19 22

17

I HEREBY CERTIFY, That I attended deceased from July 3rd, 19 22, to July 5th, 19 22, that I last saw h[illegible] alive on July 5th, 19 22, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Uremic Coloitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs symptoms

(Signed) Daniel Miller, M. D.

19 (Address) 1506 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 7 1922

20 UNDERTAKER John A Weber ADDRESS 1823 Bank St

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65726

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65726

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 863 Lemmon ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Fitchett

(a) RESIDENCE. NO. 863 Lemmon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Mar

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or estahlishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Bruce Fitchett
(Address) 863 Lemmon St

Filed JUL 6 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 2, 19 22, to July 4, 19 22, that I last saw h alive on July 4, 19 22, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) J. Norwood, M. D.

July 8, 19 22 (Address) 1939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Auburn Cem	July 9 19 22
20 UNDERTAKER David Easton.	ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65727

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Rice St ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nigel Davenport

(a) RESIDENCE. NO. 1013 Rice ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 881

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No Employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Irving Lewis Davenport

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Blanche Goldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Blanche Davenport
(Address) 1013 Rice St

15 Filed JUL 6 1922 19 H. Law Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4- 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1922, to July 4th, 1922, that I last saw h. alive on July 4th, 1922, and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. Tunnell Fargo, M. D.

, 19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 6 1922
20 UNDERTAKER Daniel Eardley	ADDRESS 914 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65728

CERTIFICATE OF DEATH.

D 65728

96

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 Shields ST., 17 WARD)

2-FULL NAME Pearl Moore

(a) RESIDENCE NO. 1140 Shields ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER George Slaughter

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Nelle Moore

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Rosie Hardy
(Address) 1140 Shields Pkwy

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to July 4, 1922.

that I last saw her alive on July 4, 1922

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E William Frey, M. D.

7/5, 19 22 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters

DATE OF BURIAL July 7 1922

20 UNDERTAKER Joseph A Farrell

ADDRESS 2319 Division

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D65729 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65729

44

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 951 Brooks Lane ST.) (13 WARD)

2-FULL NAME Caroline Block

(a) RESIDENCE NO. 951 Brooks Lane. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Simon Block.

6 DATE OF BIRTH (month, day, and year): Dec. 4 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	7	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alsace Lorraine

PARENTS
10 NAME OF FATHER: Bernard Block
11 BIRTHPLACE OF FATHER (city or town) (State or country): Alsace Lorraine
12 MAIDEN NAME OF MOTHER: Levy
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alsace Lorraine

14 Informant (Address): Mrs. L. Federlicht 951 Brooks Lane

15 Filed JUL 6 - 1922 H. Aull Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to July 6, 1922,
that I last saw h.. alive on July 6, 1922,
and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cancer of the liver

(duration) ... yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) abdominal Dropsy (duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs
(Signed) Julius Friedenwald, M. D.
7 6, 19 22 (Address) 1013 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila. Pa.
DATE OF BURIAL: 7/7/1922

20 UNDERTAKER: David Sondheim
ADDRESS: 1218 Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

65730

HEALTH DEPARTMENT—CITY OF BALTIMORE D 65730

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Cambrige ST., 1 WARD)

2-FULL NAME FRANCES KOZLOWSKI,

(a) RESIDENCE NO. 2314 Cambrige ST., I. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. II mos. I4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21-1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		II	I4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) MD.

PARENTS

10 NAME OF FATHER Joseph Kozlowski,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Alexandria Boraska,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland,

14 Informant Joseph Kozlowski,
(Address) # 2314 Cambrige Street

15 JUL 6 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 21 . 1922 . to July 5 . 1922,
that I last saw her alive on July 4 — . 1922,
and that death occurred, on the date stated above, at 5-45 a-m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Frank C Bonsal, M. D.

6/7/1922 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary.

DATE OF BURIAL July 6, 1922.

20 UNDERTAKER M F Sadowski.

ADDRESS 705 S. Ann St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118 - 00 v

D 65731

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. — ST., JOHNS HOPKINS HOSPITAL WARD 8)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Briscoe

(a) RESIDENCE No. 1513 N. Dallas ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 14 1921

7 AGE — Years | Months 9 | Days 20 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer): Baby

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Howard Chew

11 BIRTHPLACE OF FATHER (city or town) (State or country): — Md.

12 MAIDEN NAME OF MOTHER Lessie Briscoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): — Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1922, to July 5th, 1922, that I last saw him alive on July 5th, 1922, and that death occurred, on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) ... yrs. ... mos 2½ ds.

CONTRIBUTORY (Secondary) Operation.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of 7/5/22.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Horace G. Stewart, M. D.

7/5, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: July 7 1922

20 UNDERTAKER: Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65732

CERTIFICATE OF DEATH.

D 65732

161-

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 13 WARD)

2-FULL NAME Baby Jones

(a) RESIDENCE NO. 1562 Clifton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 2 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			9 1/2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Oliver Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Emma Jones (mother)

(Address) 1562 Clifton ave.

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2 , 19 22 , to July 3 , 19 22 ,

that I last saw him alive on July 3 , 19 22 ,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Maternal Syphilis Toxemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Morris Reese, M. D.

7-4, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL July 6 1922

20 UNDERTAKER .....

ADDRESS .....

JOHNS HOPKINS HOSPITAL

Commissioner Health

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

22

Spec.—1-10-21—M&T—1500 Bks.

15-6435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65733

159-03 65733

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D 65733 JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Richard Small

(a) RESIDENCE NO. 1914 N. North Ave. STR. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 8-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	—	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab Boy

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Mason Small

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Cene Small

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 JUL 6 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8th, 1922, to July 4th, 1922, that I last saw h alive on July 4th, 1922, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery) — (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of 6-19-22

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) Horace G. Stewart, M. D.

7/4, 1922. (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. 19

20 UNDERTAKER

ADDRESS

JUL 5 1922

Commissioner Health.

Please state marriage should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

222

Spec.—1-10-21—M&T—1500 Bks.

156858
~~D 65734~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 10 V D 65734

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Janice Emmond.

(a) RESIDENCE No. Glenburnie, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~or WIFE of~~ Margaret Emmonds / Stepmother

6 DATE OF BIRTH (month, day, and year): March 9, 1919

7 AGE: Years 3 | Months 3 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Robert Emmonds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Hodder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records.

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1922, to July 5, 1922, that I last saw her alive on July 5, 1922, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia + Empyema

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Emaciation

(duration) yrs. unknown mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of unknown

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

7/5 1922 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for addjtional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: July 7 1922.

20 UNDERTAKER: John F. Denny

ADDRESS 715 Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably bronchopneumonia which left child with empyema. Emaciation from empyema. Primary

D 65735

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65735

CERTIFICATE OF DEATH.

X 185

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. General Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Danilowicz

(Residence in ~~Baltimore.~~ No. 4623 Stiles St. Phila. Pa. St.; yrs., mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, December 31 (Month), 1901 (Day) (Year)

7-AGE, 20 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)..... Bethlehem Steel

9-BIRTHPLACE, (State or Country), Philadelphia

PARENTS.

10-NAME OF FATHER, Leon Danilowicz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Misizock

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon Danilowicz

(Address) 4623 Stiles St. Phila, Pa.

15-Filed JUL 6 - 1922 ROBERT A. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of left femur

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Died suddenly in water, (accident)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

July 6, 1922 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa. DATE OF BURIAL, July 6 1922

20-UNDERTAKER John F Deny ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

D 65736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 65736

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1507 Edmondson Ave ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Callis Moulton

(a) RESIDENCE NO. 1507 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm G. Moulton

6 DATE OF BIRTH (month, day, and year) July 30 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Geo R Callis

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Joanna Walsh

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Wm Moulton

(Address) 1507 Edmondson Ave

15 FILED JUL 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to July 4, 1922.

that I last saw her alive on July 4, 1922

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma with metastasis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathologic

(Signed) J. L. Dennis M. D.

7-6 1922 (Address) 904 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL July 7 1922

20 UNDERTAKER Wm F. Sweeney Sons — ADDRESS Montrose

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65737

38

D 65737

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View ST., 116 WARD)

2-FULL NAME John Reddix

(a) RESIDENCE No. Usual ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stableman

(b) General nature of industry, business, or establishment in which employed (or employer): Ost

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address)

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1. 1922

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1922 to July 1. 1922

that I last saw him alive on July 1, 1922 55 P. m.

and that death occurred, on the date stated above, at 1

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. E. Lemmert M.D.

7/11, 1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: July 6 1922

20 UNDERTAKER

ADDRESS

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65738

CERTIFICATE OF DEATH.

REGISTERED NO. 128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 Talbot Road ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Guggenheimer

(a) RESIDENCE No. 34 Talbott Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE LEGIBLY. Only Certificates in which all items are correctly answered and which are free from erasures or alterations will be accepted. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Guggenheimer

6 DATE OF BIRTH (month, day, and year): Sept. 6, 1844

7 AGE — Years: 77 Months: 10 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Abraham Hirsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Ella Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Joseph N. Ulman, 36 Talbot Road

15 Filed JUL 8 - 1922, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1922

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to July 6, 1922,

that I last saw her alive on July 5, 1922,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & blood analyses

(Signed) Charles [illegible] Krupsaw M. D.

, 19 (Address) 147 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk. Crematory

DATE OF BURIAL: 7/7 1922

20 UNDERTAKER: Harry Sondheim

ADDRESS: 118 W. Mt. Royal Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

Spec.—5-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65739

CERTIFICATE OF DEATH.

90 D 65739

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gregory

(Residence in Baltimore: No. 1417 Lanvale St.; 3 yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, (Month) (Day) 1873 (Year)

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Ford

(Address) 546 McCulloh St

15-

Filed JUL 6 - 1922, 191

ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about May 8 1922, to July 5 1922, that I saw her alive on July 4 1922, and that death occurred, on the date stated above, at 1-30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos L Dansely M. D.

July 6, 1922 (Address) 1602 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, July 7, 1922

20-UNDERTAKER James A. Deuer

ADDRESS 1203 Pennsylvania Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65740 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65740

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1317 Strucker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Brown

(a) RESIDENCE. NO. 1317 Strucker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 1901

7 AGE: Years 20 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Orleans

12 MAIDEN NAME OF MOTHER: Mina Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Mina Brown (Address) 1317 Strucker St

15 Filed JUL 6 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/5 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/20 1922, to 7/5 1922, that I last saw him alive on 7/5 1922, and that death occurred, on the date stated above, at 12-25 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Philadelphia Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhalter, M. D.

, 19 (Address) 239 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel DATE OF BURIAL: July 8 1922

20 UNDERTAKER: Hammond Edmondson & McCarey ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Rubenstein 2665741

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

HD 65741

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E Balto ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Rubenstein

(a) RESIDENCE. No. 2100 E Balto ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Simon Rubenstein

(Address) 1432 N Fulton ave.

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to July 6, 1922, that I last saw him alive on July 6, 1922, and that death occurred, on the date stated above, at 12 4 m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Wm Boyce, M. D.

7/6, 1922 (Address) 210 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern	July 7 1922

20 UNDERTAKER May Levinson ADDRESS 1107 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65742

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yfostos Macri

(a) RESIDENCE. No. 715 S. Broadway ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Gabriel Macri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Carlleo Achille

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records, (Address) M.T.H.

15 Filed JUL 6 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to July 5, 1922.

that I last saw him alive on July 5, 1922.

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T. B. In sputum, X-ray

(Signed) Francis L. Dadaglianes M. D.

7-5-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 7/7 1922

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins St

Burial Permit Clerk.

ROBERT R. KRAUTER

N. B.—WRITE PLAINLY, with pen and ink. All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 15-M-7-14-3D & T.—2000 Bks.

D 65743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3D 65743

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S Belnord Ave St.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry F. Mooney

(Residence in Baltimore: No. 812 S Belnord Ave St.; — yrs., 5 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan (Month) 19 (Day), 1922 (Year)

7-AGE, — yrs. 5 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Harry Mooney

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Bertha Brandt

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Harry Mooney

(Address) 812 S Belnord Av

15- Filed JUL 9 - 1922, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5 1922, to July 6 1922, that I saw [illegible] alive on July 5 1922, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza Toxic

(Duration) yrs. mos. ds.

(Signed) W. L. Lee M. D.

July 6, 1922 (Address) 3701 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Germain

DATE OF BURIAL, July 7, 1922

20-UNDERTAKER Peter Nicolaus

ADDRESS Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65744

CERTIFICATE OF DEATH.

D 65744

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Bowleys Lane & 2nd St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Laubach.

(a) RESIDENCE. NO. Bowleys Lane & 2nd St. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12. 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	X	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Bowleys Lane 2nd & Franklin Avs

PARENTS
10 NAME OF FATHER Christian Laubach
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md
12 MAIDEN NAME OF MOTHER Hannie Seibert
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Christian Laubach
(Address) Bowleys Lane & Franklin Ave

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 5, 1922, that I last saw h[illegible] alive on July 5, 1922, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:
Exhaustion
Lobar Pneumonia

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) measles.
(duration) X yrs. X mos. 2 ds.

18 Where was disease contracted if not at place of death? Same.
Did an operation precede death? No Date of No
Was there an autopsy? No
What test confirmed diagnosis? Same
(Signed) Jas L. Evans, M. D.
(Address) 2485 So 30 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn.

DATE OF BURIAL July 7th 1922

20 UNDERTAKER Leo G. Cook

ADDRESS Northboro

N. B.—Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks

D 65745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65745

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Boyd

(a) RESIDENCE NO. R#4 Norfolk, Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT BECOMES A PERMANENT RECORD, AND ERRORS OR OMISSIONS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X X

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Frank T. Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Hattie Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 6 - 1922 ROBERT A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to July 6, 1922, that I last saw her alive on July 6, 1922 and that death occurred, on the date stated above, at 12 15 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis ?

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture and autopsy

(Signed) Francis R. Dieuaide, M. D.

July 6, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Norfolk Va DATE OF BURIAL 7/7/22

20 UNDERTAKER ROBERT. BROOKS & SON ADDRESS CALHOUN HOLLINS ST

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65746

CERTIFICATE OF DEATH.

74 001

D 65746

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 W. Lanvale ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet A. Frazier

(a) RESIDENCE NO. 1604 W. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 22-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Frazier

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Adaline Sullivan

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant R. Clarence Frazier
(Address) 857 Harlem Ave.

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th, 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11— 1916 to July 6— 1922,

that I last saw h[illegible] alive on about one year ago, 19

and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Probable Cerebral apoplexy

(sudden death)

about 15 to 20 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis & Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? ~~No~~ Nature & Knowledge of case

What test confirmed diagnosis?

(Signed) Carlton M Cook M. D.

July 7, 1922 (Address) 1107 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery

DATE OF BURIAL: July 8th 1922

20 UNDERTAKER: Putnam & Gore

ADDRESS: 1733 W Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65747

D 65747

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 812 W Baltimore St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry A. Van Daniker

(Residence in Baltimore: No. 812 W Baltimore St.; 47 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Don't Know (Month) (Day) (Year)

7-AGE: 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE (State or Country): Balt City

PARENTS:

10-NAME OF FATHER: John van Daniker

11-BIRTHPLACE OF FATHER (State or Country): City

12-MAIDEN NAME OF MOTHER: Mary Schaub

13-BIRTHPLACE OF MOTHER (State or Country): Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Little

(Address) 2700 Edmonson Ave

15-FILED JUL 6- 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 5 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or Inquiry.~~ thereon and from the evidence obtained by said ~~Inquest, autopsy or Inquiry.~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) ..... yrs. Don't Know mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. Don't Know mos. ..... ds.

(Signed) W. K. Krauter M. D. (Coroner.)

7-6 1922 (Address) 117 W. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem

DATE OF BURIAL: July 6 1922

20-UNDERTAKER: Geo. W. Little

ADDRESS 2700 Edmonson Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65748

D 65748

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N. Rose St., 6 WARD)

2-FULL NAME Charles J. Leitner

(a) RESIDENCE NO. 16 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Leitner

6 DATE OF BIRTH (month, day, and year) July 2 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	64		2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Antone Leitner

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Catherine Leitner
(Address) 16 N Rose St

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1922, to July 4th 1922.

that I last saw him alive on July 4th 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robert J. Kirk, M. D.

7/5/22 (Address) 3126 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 7 22

20 UNDERTAKER Jos C Miller — ADDRESS 2334 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65749

CERTIFICATE OF DEATH.

161 001 D 65749

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S Bond ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christyna Damico

(a) RESIDENCE. No. 617 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 6 1922

7 AGE: Years Months Days: If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none — 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Damico

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Christyna Syprich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pittsburg Penn

14 Informant (Address): Charles Damico 617 S Bond

15 Filed JUL 6 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6 1922 to July 6 1922

that I last saw h[illegible] alive on July 6 1922

and that death occurred, on the date stated above, at 2300 P m.

The CAUSE OF DEATH* was as follows:

I Pneumonia Bilat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur J Ryan M. D.

19 (Address) 1401 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: July 7 1922

20 UNDERTAKER: John A Weber

ADDRESS: 1803 Bank St

D 65750 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65750

CERTIFICATE OF DEATH.

Registered No. C 113

1-PLACE OF DEATH

City of BALTIMORE: (No. 582 Preston St. Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Naomi Randall

(Residence in Baltimore: No. 582 Preston St. St.; yrs. 2 mos. 14 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word) Single

6-DATE OF BIRTH, April 11 (Month) (Day) 1920 (Year)

7-AGE, yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Roland Jones

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Alice Randall

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Randall

(Address) 582 Preston St.

15-

Filed JUL 7 - 1922 G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

(Signed) J. T. Hammond M. D. (Coroner.)

July 6 1922 (Address) 2802 Edmondson

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, July 7 1922

20-UNDERTAKER, Samuel Hawkey ADDRESS 575 N Bond

Spec.—1-10-21—M&T—1500 Bks.

D 65751 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D 65751

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 E. Eager St. ST., 10 WARD)

2-FULL NAME Joseph. C. Grevelding

(a) RESIDENCE NO. 1405 E. Eager St. ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Grevelding

6 DATE OF BIRTH (month, day, and year) Oct.-10-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mathias Grevelding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schwarz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Mary Fisher
(Address) 1405 E Eager St.

15 Filed JUL 7- 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-6-1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1. 1922 to July 5. 1922.

that I last saw him alive on July 5. 1922

and that death occurred, on the date stated above, at 9:25 A.M. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Cirrhosis Liver

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 2 years ago.

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. J. Lebold, M. D.

, 19 (Address) 1301 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July-8-1922

20 UNDERTAKER: Henry Horch Son — ADDRESS: 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D 65752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65752

CERTIFICATE OF DEATH.

74-061

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 N. Broadway ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Wright

(Residence in Baltimore: No. 1735 N. Broadway St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 18 (Day), 1858. (Year)

7-AGE, 64 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thomas W. Kerr

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen J. Williamson

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella W. Murphy

(Address) 1735 N. Broadway

15- Filed JUL 7 - 1922, 191.... H. Ahrens Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 5 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30 1922, to July 5 1922, that I saw h[illegible] alive on July 5 1922, and that death occurred, on the date stated above, at 12-45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) 3 yrs. ....mos. ....ds.

(Signed) Robert J. Green M. D.

July 6, 1922 (Address) 120 Asquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, July 8...., 1922

20-UNDERTAKER John B. Lynch

ADDRESS 1326 N. Caroline St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65753

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3308 Elgin ave. ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Jane Evans

(a) RESIDENCE. No 3308 Elgin ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City (State or country) Md.

PARENTS

10 NAME OF FATHER Ray O. Evans

11 BIRTHPLACE OF FATHER (city or town) Columbus (State or country) Ohio

12 MAIDEN NAME OF MOTHER Helen H. Holter

13 BIRTHPLACE OF MOTHER (city or town) Columbus (State or country) Ohio

14 Informant Ray O. Evans

(Address) 3308 Elgin ave.

Filed JUL 7 - 1922 19 Registrar

Via Penn. Railroad

Escort - Ray O. Evans

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 - 1922

17

I HEREBY CERTIFY, That I attended deceased from July - 2 - 1922, to July - 6 - 1922, that I last saw her alive on July 6 - 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute fulloid atrophy of liver

- (duration) - yrs. - mos. 4 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Consultation Dr. R. T.

(Signed) J. Wesley Cole, M. D.

6/7, 1922 (Address) 2702 Fenwick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Columbus, Ohio	7/7, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec.—6-9-19—H. P. Cc.—1006 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65754

D 65754

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) Municipal Tuberculosis ST. 17 WARD)

2-FULL NAME Bernard Nelson

(a) RESIDENCE. NO. 565 Orchard st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ----

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Odessa Nelson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 7 - 1922, 19 W.A. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from November 2, 1921, to July 5, 1922, that I last saw him alive on July 5, 1922, and that death occurred, on the date stated above, at 8.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis Dodgheca, M. D.

7-6-1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 8 1922

20 UNDERTAKER David Easlor ADDRESS 86

65755

D 65755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 769 Bradley St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marshall Lockeretta

(Residence in Baltimore: No. 769 Bradley, St., St.; yrs., 4 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: March 24 1918 (Month) (Day) (Year)

7-AGE: 4 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Wm. Lockeretta

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Sallie Fowler

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lockeretta

(Address) 769 Bradley St.

15-

Filed JUL 7 - 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

July 6 1922 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: July 8 1922

20-UNDERTAKER: David Earle ADDRESS: Pa. Ave.

916 Pa. Ave.

Spec.—1-10-21—M&T—1500 Blks.

D 65756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65756

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Woodyear ST., 16 WARD)

2-FULL NAME Henry Green

(a) RESIDENCE No. 1125 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sally Green

6 DATE OF BIRTH (month, day, and year) ? 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) West River (State or country) Md.

PARENTS

10 NAME OF FATHER Osborne Harris

11 BIRTHPLACE OF FATHER (city or town) West River (State or country) Md.

12 MAIDEN NAME OF MOTHER Betsy Green

13 BIRTHPLACE OF MOTHER (city or town) West River (State or country) Md

14 Informant Ruth Boyer (Address) 1129 Woodyear

15 FILED JUL 7 - 1922 H. A. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to July 5, 1922, that I last saw him alive on July 5, 1922 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

7/5, 1922 (Address) 1928 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 7 1922
20 UNDERTAKER	ADDRESS
John H Taddrien	1121 N Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65757

179

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Spring Ave. ST. Rasp 6th WARD)

2-FULL NAME Maria Louise Webster

(a) RESIDENCE No. 1 Spring Ave. ST., Rasp WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Webster

6 DATE OF BIRTH (month, day, and year) Sept. 22nd 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	72	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 03

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm H. Hooper

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Hodges

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mary L. Jones (Address) 1 Spring Ave

15 Filed JUL 1922. 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to July 5, 1922, that I last saw her alive on July 5, 1922, and that death occurred, on the date stated above, at 4 P.M. a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart.

(duration) yrs. mos. 7 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Webster, M. D.

, 19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL July 8 1922

20 UNDERTAKER Frank Lassahn Sons — ADDRESS Fulberton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65758 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65758

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 Giorgia ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Warren

(Residence in Baltimore: No. 734 George St.; 116 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, (Month) unknown (Day) (Year) 1846

7-AGE. 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Maid
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Rockdale Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jessie Nelson

(Address) 1132 Druid Hill Ave

15- Filed JUL 7 - 1922, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1922, to July 4th 1922, that I saw h.. alive on July 4th 1922, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) none known

(Duration) yrs. mos. ds.

(Signed) Chas. Keller M. D.

July 7th, 1922 (Address) 711 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL JUL 7 1922

20-UNDERTAKER Samuel P. Hamberger ADDRESS 578 N. Biddle

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.- 1-10-21 M&T 1500 Bks.

D 65759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65759

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 E. 35th ST., 9 WARD)

2-FULL NAME George [redacted] Eisinger

(a) RESIDENCE NO. 613 E. 35th. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Louie Eisinger

6 DATE OF BIRTH (month, day, and year) July 1, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Carver

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Paul L. Eisinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louie Eisinger

(Address) 613 E. 35th St.

15 Filed JUL 7 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-1922

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to July 4, 1922.

that I last saw h[redacted] alive on July 3, 1922.

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Arter. Scl. Cerebri

(duration) 2 yrs. - mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) P.J. Dell, M. D.

7/7, 1922 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill, Towson DATE OF BURIAL: July 7, 1922

20 UNDERTAKER: William Cook, ADDRESS: 502 E. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dell 33 W Lombard St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Uremia
Probably due to
chronic nephritis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65760

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Josephs Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thomas J. O'Toole

(Residence in Baltimore: No. St ~~Dominicks Hospital~~ Institution Hamilton Md yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

6-DATE OF BIRTH. March 25 1890.
(Month) (Day) (Year)

7-AGE. 32 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clergyman
(b) General nature of Industry, business, or establishment in which employed (or employer)..... R.C.

9-BIRTHPLACE, (State or Country). Connelsville Pa

PARENTS.

10-NAME OF FATHER. Thomas O'Toole

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas O'Toole

(Address) Cumberland Md.

15-

Filed JUL 7 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull,
Fell from rectory window,
accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J S K Catts M. D.
(Coroner.)

7-7 1922 (Address) 508 E North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

~~Where was disease contracted, if not at place of death?~~ Rectory Yard.

Former or usual residence. Northern Ave Balto.

19-PLACE OF BURIAL OR REMOVAL. St Mary's Cem Cumberland — DATE OF BURIAL. 7/11 1922

20-UNDERTAKER. George J Ruth — ADDRESS 1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65761

CERTIFICATE OF DEATH.

113 D 65761

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Collington Ave ST.; 16 WARD)

2-FULL NAME Dolores Enoch

(a) RESIDENCE. NO. 916 N. Collington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 15/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9.	21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER James Enoch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Jones Enoch 916 N Collington Ave

15 Filed JUL 7 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 2 19 22, to July 6 19 22,

that I last saw her alive on July 6 19 22,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Hagner, M. D.

(Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 9 19 22

20 UNDERTAKER Frank Enoch & Son ADDRESS 916 N Collington Ave

D 65762 HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

D 65762

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonio J. Ferris

(Residence in Baltimore: No. 124 N. Glover St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): ~~Single~~

6-DATE OF BIRTH: January 10 1913
(Month) (Day) (Year)

7-AGE: 9 yrs. 5 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer): Boy

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER, Martin Antonio Ferris

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Emma Burkhauser

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin

(Address) 124 N Glover St

15-

Filed JUL 7 - 1922 GLS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage
Fractured Skull
Hit by automobile, driven by Mr. Harris

Duration: ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Accidental

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. T. Walker M. D.
(Coroner.)

7-6 1922 (Address) 505 E. Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.
Holy Redeemer July 8 1922

20-UNDERTAKER, ADDRESS
Jos. J. Herr & Son 1506 N. Luzerne Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65763

CERTIFICATE OF DEATH.

1127 D 65763

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 548 E. Fort Ave. St.) 24 (WARD)

2-FULL NAME Melda In Kelly

(a) RESIDENCE. No. 548 E Fort Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1916

7 AGE — Years: 5 — Months: 6 — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Dr John Kelly
(Address) 548 E Fort Ave

15 JUL 7 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 6, 1922, that I last saw her alive on July 6, 1922, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

a Acute Dilatation of Heart

(duration) yrs. mos. 2 hrs ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Mullen, M. D.

19 (Address) 7 Pelham Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	July 8 1922
20 UNDERTAKER	ADDRESS
Margaret E Flynn	1422 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65764

Sp. ... & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65764

CERTIFICATE OF DEATH.

REGISTERED NO. C 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Szymkowiak

(Residence in Baltimore: No. 511 S. Lakewood Ave St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, February 3, 1892
(Month) (Day) (Year)

7-AGE, 30 yrs. 5 mos. 3 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... machinist 631
(b) General nature of industry, business, or establishment in which employed (or employer) ... Sparrow Point

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Szymkowiak

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Jaskowiak

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Szymkowiak

(Address) 511 S. Lakewood

15-

Filed ..., 191... Registrar.

JUL 7 - 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 24 1922, to July 5 1922 that I saw h[illegible] alive on July 5 1922 and that death occurred, on the date stated above, at 2.38 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. W. Bluney M. D.

..., 191... (Address) 511 S. Lakewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross, Hillen Road — DATE OF BURIAL, July 8, 1922

20-UNDERTAKER Wendell Apple & Son — ADDRESS 37 [illegible]

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

Neilan

D 65765 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 65765

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1810 Duncan ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Neiten

(a) RESIDENCE NO. 1810 Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Neiten

6 DATE OF BIRTH (month, day, and year) Aug 12 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Cordell

(Address) 1810 Duncan St

15 JUL 7 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1922

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to July 6, 1922,

that I last saw h[illegible] alive on July 5, 1922,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

, 19 (Address) 1812 N. Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL July 8 1922

20 UNDERTAKER Pott & Turner

ADDRESS 1442 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65766

CERTIFICATE OF DEATH.

100, 01 D 65766

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Fazino

(a) RESIDENCE. NO. 726 Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 086

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER John Fazino

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosa

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant B. J. Sweeney
(Address) Warden Md. Pen.

15 Filed JUL 7 - 1922 19 ROBERT R. KRAUTER, Registrar
Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June - 24, 1922, to July - 6, 1922, that I last saw him alive on July - 6, 1922, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure. Inanition - Melancholia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William H. Schwartz, M. D.

7/6, 1922 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent Cemetery — DATE OF BURIAL: 7/8 19

20 UNDERTAKER: [illegible] — ADDRESS: 1235 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65767

CERTIFICATE OF DEATH.

113 D 65767

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 S Curley, ST., 1 WARD)

2-FULL NAME Albert Hartwick

(a) RESIDENCE NO. 815. S Curley. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 11 - 1921

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 000

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jacob. Hartwick.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Stella Kowalek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Jacob. Hartwick

(Address): 815. S Curley.

15 Filed JUL 7 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to July 7, 1922

that I last saw h...live on July 7, 1922

and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) W. L. Burke, M. D.

. 19 (Address) 3040 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: 7/8 1922

UNDERTAKER: Wm Fallsowsky

ADDRESS: 168 Eastern

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65768

113 D 65768

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 24 WARD)

2—FULL NAME Salvatore Dan Torio.

(a) RESIDENCE NO. 1625 Cuba ST., Forest Park.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27 22

7 AGE — Years: — Months: 8 Days: 10. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ———

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Pasquelle Dantonio.

11 BIRTHPLACE OF FATHER (city or town) Italy. (State or country)

12 MAIDEN NAME OF MOTHER Josephine Lauda

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Pasquale Dan Torio (Address) 1625 Cuba St

15 JUL 7-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to July 7, 1922, that I last saw h[illegible] alive on July 7, 1922, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Entero - Colitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia Malnutrition

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) L. J. Cronquist, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 11 1922

20 UNDERTAKER: J O Mitchell — ADDRESS: 1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65769

D 65769

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa M F Howard

(Residence in Baltimore: No. 1936 Christian a St.; yrs....mos....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Single

6-DATE OF BIRTH. Oct (Month) 21 (Day) 1918 (Year)

7-AGE. 3 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). ppp

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Francis Howard

11-BIRTHPLACE OF FATHER (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Viola Howell

13-BIRTHPLACE OF MOTHER. (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) viola Howard

(Address) 1936 Christian st

15- Filed JUL 7 - 1922

ROBERT R. KRAMER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day) 1922. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Subdural Hemorrhage

Cause unknown

(Duration) ....yrs. ....mos. 1/2 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. 1/2 ds.

(Signed) James J. Mc[illegible] M. D. (Coroner.)

July 7 1922 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. 1/2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1936 Christian

Former or usual residence. " "

19-PLACE OF BURIAL OR REMOVAL. Western DATE OF BURIAL, July 8, 1922

20-UNDERTAKER, John J Fields ADDRESS 1202 N Fountain

Remarks.....

History at Hosp. very vague. Child entered in convulsions. No further history.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 65770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90

D 65770

REGISTERED NO.

1-PLACE OF DEATH Garrett Hospital for Children. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Alfred McGee.

(a) RESIDENCE NO. Pasadena. Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie L Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James McGee
(Address) Pasadena Md

15 Filed JUL 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Cat.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 6, 1922.

that I last saw him alive on July 6, 1922;

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis }
Myocarditis. }

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Charles L Warner, M. D.

, 19 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 8 1922

20 UNDERTAKER John L Fields — ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Maikaila

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65771 D 65771

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 666 Redwood St. 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Antonio Mikaila

(Residence in Baltimore: No. 666 Redwood st St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Dont Know (Month) (Day) 1..... (Year)

7-AGE. 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Tailor 080 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. B. Kauchances.

(Address) 648 Washn. Boul.

15- Filed JUL. 7 - 1922 ROBERT B. KRAUTER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 5 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Ens death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 4 mos. weeks ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) J. H. Gorsuch M. D.

(Coroner)

7-7- 1922 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem DATE OF BURIAL. 7/8/22 19

20-UNDERTAKER. Geo. J. Puth ADDRESS 1735 Hanford Ave

D 65772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 65772

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Kelly Mercy Hosp ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kelly

(Residence in Baltimore: No. 937 W Lombard St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1862 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): U. S. Government

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Kelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margert Ward

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Eugene F. Flannery

(Address) 2553 Edmondson Ave

15- Filed JUL 7 - 1922, 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis Interstitial

Duration ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia

Hanson Barry (Duration) ... yrs. 2 mos. ... ds.

(Signed) W. S. Kelly M. D.
(Coroner.)

July 7, 1922 (Address) 1039 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem

DATE OF BURIAL, July 7, 1922

20-UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 C D 65773

~~D 65773~~ PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 1633 N. Caroline St. ST.; 8 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irawice N De Witt

(a) RESIDENCE. No. 1638 N Caroline St. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W'h	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Canal Holibird

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Calvus E DeWitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Houston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Laura Green

(Address) 1633 N Caroline St

Filed JUL 8 - 1922 LD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1922

17

I HEREBY CERTIFY, That I attended deceased from July 4th, 1922, to July 6th, 1922

that I last saw him alive on July 6th, 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) I do not know yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Appearance and Examination

(Signed) J. B. Schwatka, M. D.

, 19 (Address) 822 W. North Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	July 8 1922
20 UNDERTAKER	ADDRESS
Martin Baker Son	827 W North

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65774

CERTIFICATE OF DEATH.

15

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 W. West ST.: 23 WARD)

2-FULL NAME Annie E Prince

(a) RESIDENCE. No. 102 W West ST., 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Edward H Prince

6 DATE OF BIRTH (month, day, and year) March 10, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Christian Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Fuel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edward H Prince

(Address) 102 W. West St

Filed JUL 8 - 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1922, to July 6 1922, that I last saw h alive on July 6 1922, and that death occurred, on the date stated above, at 1.35 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Senility Feeding + season

(duration) yrs. mos. 6 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Mitchell M. D.

7/6, 1922 (Address) 1211 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: July 8 1922

20 UNDERTAKER: Mrs J E Evans & Sons — ADDRESS: 1428 S Hanover St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65775

HEALTH DEPARTMENT—CITY OF BALTIMORE

65775

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 E. Madison ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin E. Smith

(a) RESIDENCE. No. 1504 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col.	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 26 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va. Md

12 MAIDEN NAME OF MOTHER Sarah E. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Sarah E. Smith

(Address)

15 Filed JUL 8 1922 H. A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922 to July 7, 1922

that I last saw him alive on July 7, 1922,

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal Catarrh

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Robt Robinson, M. D.

July 8, 1922 (Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 8 1922
20 UNDERTAKER	ADDRESS
Mrs. C. Elliott	1727 Aisquith

Spec.—1-10-21—M&T—1500 Bks.

D 65776 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65776

CERTIFICATE OF DEATH

1-PLACE OF DEATH Municipal Hospital REGISTERED NO. 129

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Smith

(a) RESIDENCE NO. ..... Pearl St ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home Work

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Perry

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant (Address) Hosp. Records

15 Filed JUL 8 - 1922 19 H. Lane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/1922

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 1922 to 7/6, 1922

that I last saw her alive on 7/6, 1922

and that death occurred, on the date stated above, at 7:55 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Clyde O'Neill M. D.

7, 1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL July 7 1922

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 65777

D 65777. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Southern Ave ST. 27 WARD)

2-FULL NAME Carolina Rosenbauer

(a) RESIDENCE NO. 117 Southern Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto W: Rosenbauer

6 DATE OF BIRTH (month, day, and year) Apr 6th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Rauber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Hauf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto W: Rosenbauer

(Address) 117 Southern Ave

15 Filed JUL 8 1922. 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 27 19 22 to July 6 19 22.

that I last saw h[illegible] alive on July 6 19 22

and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows: "Acute Nephritis"

Uremia

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles A. Mey M. D.

July 9 19 22 (Address) 103 N. Carrollene st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL July 10 19 22

20 UNDERTAKER J Merrick ADDRESS 2008 Callow

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65778

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 So. Chester St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lorenzo D. Dixon

(Residence in Baltimore: No. 206 So. Chester St.; 27 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: May (Month) 24th (Day) 1875 (Year)

7-AGE: 47 yrs. 1 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Collector
(b) General nature of industry, business, or establishment in which employed (or employer): for Jewelry Firm

9-BIRTHPLACE, (State or Country): N. C.

PARENTS.

10-NAME OF FATHER: Henry O. Dixon

11-BIRTHPLACE OF FATHER, (State or Country): N. C.

12-MAIDEN NAME OF MOTHER: Mary Bradley

13-BIRTHPLACE OF MOTHER, (State or Country): N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Dixon

(Address) 206 So. Chester St

15- Filed JUL 8 - 1922 19.. 11 A.M.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

1 hour

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. E. Horton M. D.
(Coroner)

July 7 - 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal. Natural

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery DATE OF BURIAL, July 9, 1922

20-UNDERTAKER, J. Vander & Sons ADDRESS 1100 Hunt St

D 65779

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 65779

REGISTERED NO. C.....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Harford Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Jenkins

(Residence in Baltimore: No. 2114 Harford Ave St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1895 (Year)

7-AGE: 27 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 17

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: John. Jenkins

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Mary Nelson.

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary. Jenkins

(Address) 2114 Harford Ave

15- JUL 8 - 1922 191.....

H. A. W.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4th, 1922, to July 7th 1922, that I saw her alive on July 6 1922, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Streptococcus) from infected nose

(Duration) ..... yrs ..... mos. 6 ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) T. X. Lumpey M. D.

July 7 1922 [Address] 2106 Harford Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Parkwood Cem

DATE OF BURIAL: July 9th 1922

20-UNDERTAKER: Leo. G. Cook

ADDRESS: North & Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65780

14-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 S. Stricker ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma McKnew Day

(a) RESIDENCE. No. 306 S. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2nd 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework DM

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER John Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co

12 MAIDEN NAME OF MOTHER Emily McKnew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co

14 Informant Mrs. M. O Warfield

(Address) 306 S Stricker St

15 Filed JUL 8 - 1922 19 N. A. Hill Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/18, 1921, to July 6, 1922,

that I last saw her alive on July 6, 1922,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Hemi-plegia

Cerebral

(duration) 13 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arthritis deformans

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Irvington-Balto.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robt. A. Hamer M. D.

7/8 1922 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morgan Chapel Cem	7-9th 1922
20 UNDERTAKER	ADDRESS
Robt. Brooks & Son	Calhoun Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65781

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 S Furrow ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ross. Geo. McAfee

(a) RESIDENCE. NO. 329 S Furrow ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Ross. G. McAfee

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Gutman

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Ross G. McAfee
(Address) 329 S. Furrow St.

15 Filed JUL 8 - 1922 19 W. A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 — 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 7, 1922, that I last saw h. alive on July 7, 19 , and that death occurred, on the date stated above, at 12. P. m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteric Infection

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Katen, M. D.

July 7, 1922 (Address) 2027 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 8 1922

20 UNDERTAKER George C. Schwab. ADDRESS 21 S Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65782 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65782

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 Ridgely ST. 21 WARD)

2-FULL NAME Bessie Thelma Gore

(a) RESIDENCE. No. 1144 Ridgely ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 15, 1921

7 AGE — Years: 1 — Months: 2 — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 060

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Geo. H. Gore

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Louis Mo.

12 MAIDEN NAME OF MOTHER: Bessie E Mayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Louis Mo.

14 Informant: Bessie E. Gore
(Address): 1144 Ridgely St.

Filed JUL 8 - 1922 H. A. C. C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1922

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1922, to July 7, 1922, that I last saw h[illegible] alive on July 7, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell, M. D.

July 8 1922 (Address) 1644 Harwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 7/8- 1922

20 UNDERTAKER: W. J. Tichnerton — ADDRESS: North Penn

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 65783

D 65783 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 W. Lafayette Ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Williams

(a) RESIDENCE. No. 1804 W. Lafayette Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Williams

6 DATE OF BIRTH (month, day, and year) Aug., 25/ 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Constable in

(b) General nature of industry, business, or establishment in which employed (or employer) People's Court

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Delaney Handehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margaret E. Williams
(Address) 1804 W. Lafayette Ave.

Filed JUL 8 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7. 1922

17 I HEREBY CERTIFY, That I attended deceased from for past 10 yrs. to July 7. 1922, that I last saw h[illegible] alive on July 7. 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Due to a chronic
Interstitial Nephritis
and Arterio Sclerosis
Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) 824 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL July 10 1922

20 UNDERTAKER Chas. F. Evans & Son

ADDRESS 118 W. Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65784

58,001

58 D 65784

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 438 E. 22nd St. ST., 12 WARD)

2-FULL NAME Teresa Hoff

(a) RESIDENCE NO. 438 E. 22nd St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Wilbur Hoff

6 DATE OF BIRTH (month, day, and year) June 10" 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas C. Scharf

11 BIRTHPLACE OF FATHER (city or town) Harford Co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Rockwell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Mr. Snowden Hoff

(Address) 2433 Edmondson Ave.

15 Filed JUL 8- 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7" 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 2 to July 7. 1922

that I last saw h alive on July 7. 1922

and that death occurred, on the date stated above, at 10.20A. m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

Arteriosclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reuben Lee Dennis, M. D.

7/7, 1922 (Address) 824 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL July 10" 1922

20 UNDERTAKER Joseph B. Cook's ADDRESS 1003 N. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15-6917 D 65785

CERTIFICATE OF DEATH.

32 D 65785

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley C. Bain

(a) RESIDENCE. No. 937 Madison Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 26th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Emil C. Bain

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Mary Platt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 8 - 1922 Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be filled in. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1922, to July 8th, 1922, that I last saw h[illegible] alive on July 8th, 1922, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningetes

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lumbar puncture + Tuberculin

(Signed) Horace G. Stewart, M. D.

7/8, 19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 10 1922

20 UNDERTAKER Jos B Cook — ADDRESS 1003 N Balto

Spec.—1-10-21—M&T—1500 Bks.

D 65786 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65786

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1540 N. Fulton Ave. ST., 15 WARD)

2-FULL NAME Sarah Jane Miller

(a) RESIDENCE NO. 1540 N. Fulton Ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Miller

6 DATE OF BIRTH (month, day, and year) May 13th 1847

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
85	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Caroline Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Robert Montgomery

11 BIRTHPLACE OF FATHER (city or town) Caroline Co.
(State or country) Va.

12 MAIDEN NAME OF MOTHER Elza Haslup

13 BIRTHPLACE OF MOTHER (city or town) Caroline Co.
(State or country) Va.

14 Informant Mrs. C. E. Durben
(Address) 1540 N. Fulton Ave.

15 Filed JUL 8 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 7, 1922, that I last saw her alive on July 6, 1922, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ~ yrs. 9 mos. ~ ds.

CONTRIBUTORY (Secondary) Arterio sclerosis,

(duration) 3 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Shannon M. D.

July 7th 1922 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edgar Hill Cem — DATE OF BURIAL July 10th 1922

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Balto St

D 65787. HEALTH DEPARTMENT—CITY OF BALTIMORE D 65787.

CERTIFICATE OF DEATH. 179

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Vernon J. Long

(Residence in Baltimore: No. 310 S Fulton ave St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Jan (Month) 1 (Day) 1920 (Year)

7-AGE: 2 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER, Wm F Long

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER, Sophie C Meier

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F Long

(Address) 310 S Fulton ave

15- Filed JUL 8 - 1922 192 H. Lane Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurymen (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

2° Burns over greater part of body & face, while playing with matches accident (Duration) .....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) James M Fenton M. D. (Coroner.)

July 7 1922 (Address) 100 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death .....yrs.....mos. 3 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

310 S Fulton ave

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, July 8 1922

20-UNDERTAKER, Harry H Witz ADDRESS 1531 W Lombard

D 65788 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65788

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 833 Leadenhall St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warner Johnson. (C). 40 ----------.

(Residence in Baltimore: No. 833 Leadenhall St. St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. Do not know. ....., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
50 yrs. -- mos. -- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Danville Va.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Johnson. (C)(wife).

(Address) 833 Leadenhall Street.

15- JUL 8 - 1922 192.. GG Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1st. 1922. ....., 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

July 7, 192 2. (Address) 1014 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
UNIVERSITY OF MARYLAND	July 8 1922
20-UNDERTAKER. (Commissioner Health.	ADDRESS

19341 THE MORGUE.

Spec.—1-10-21—M&T—1500 Blks.

D 65789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65789

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Municipal Hospital 96

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Green

(a) RESIDENCE NO. Boy Ave ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should study CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced, (write the word): D

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 75 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant .....

(Address) .....

15 Filed JUL 8 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/3/1922

17 I HEREBY CERTIFY, That I attended deceased from 4-19-, 1922 to 7/3, 1922

that I last saw him alive on 7/3/, 1922

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Clyde Mowell, M. D.

7/7, 1922 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL July 8 1922

20 UNDERTAKER: Commissioner Health.

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65790

D 65790

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH Municipal Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 22 WARD)

2-FULL NAME Robert Green

(a) RESIDENCE NO. 316 S Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hy Record

15 Filed JUL 8 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4/1922

17 I HEREBY CERTIFY, That I attended deceased from 4-28-, 1922 to 7-4-, 1922

that I last saw h[illegible] alive on 7-4-, 1922

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no ex

What test confirmed diagnosis?

(Signed) Clyde Mowell M. D.

7/4, 1922 (Address) Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: July 8 1922

20 UNDERTAKER: Commissioner Health

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65791

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 3 WARD)

2-FULL NAME William Jackson

(a) RESIDENCE. No. 614 S. Spring st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Washington Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Emiline Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address) Hospital Records M.T.H.

Filed JUL 8 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to July 5, 1922, that I last saw him alive on July 5, 1922, and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) Frances L. Sadaphicara M. D

7-5-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL July 8 1922

20 UNDERTAKER Commissioner Health.

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65792 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65792

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Underwood

(a) RESIDENCE. No. 228 S. Bethel st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Aberth Underwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Rockesey Hicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant (Address) Hospital Records U.T.H.

Filed JUL 8 - 1922, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1922, to July 6, 1922, that I last saw him alive on July 6, 1922, and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Gallagher M. D

7-7-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: July 8 1922

20 UNDERTAKER: [illegible]

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 65793

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65793

CERTIFICATE OF DEATH.

1 Lindeman

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St. 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm N. Lindeman Jr.

(a) RESIDENCE. No. 3408 Harford Road Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm N. Lindeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Helen Schuetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm Lindeman
(Address) 3408 Harford Ave

15 Filed JUL 8 - 1922 19 J E Welsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17

I HEREBY CERTIFY, That I attended deceased from June 14 1922 to July 7 1922,

that I last saw h.IM alive on July 7 1922,

and that death occurred, on the date stated above, at 17:30 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

Myocardial (Toxemia) failure

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Typhoid Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Widal + Blood Culture

(Signed) Conrad Gelman, M. D.

19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loratzo Cemetery	July 11 1922
20 UNDERTAKER	ADDRESS
Mendel & Lappe	5 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65794

CERTIFICATE OF DEATH.

1901 74 D 65794

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1915 Penna Ave. WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Elizabeth Austin

(a) RESIDENCE. NO. 1915 Penna Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Moses Austin

6 DATE OF BIRTH (month, day, and year): Jan. 1850

7 AGE: Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer): ~ of ~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charlottesville Virginia

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Sally Cousins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charlottesville Virginia

14 Informant (Address): Anna R. Bell 1915 Penna Ave

15 Filed JUL 8 - 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 4, 1922, that I last saw h.. alive on July 4, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Cerebral hemorrhage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) John E. J. Campbell, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlottesville Va	July 8 1922
20 UNDERTAKER	ADDRESS
George T. A. Gibson	5 13 Fauquier

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65795

CERTIFICATE OF DEATH.

D 65795

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Provident Hospital ST., (WARD)

2-FULL NAME Infant J Margaret Smith

(a) RESIDENCE NO. 1411 Druid Hill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 4th 1922

7 AGE Years Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wilford Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Alice Jackson

(Address) Provident Hospital

15 Filed JUL 8 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1922 to July 7, 1922

that I last saw h alive on July 7, 1922

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J B Hughes, M. D.

1922 (Address) 1413 E. Hill Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL July 8 22

20 UNDERTAKER George H. Holland ADDRESS 1631 Aisquith Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D65796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

802 D65796

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere Av-W-of-Roland Av ST.: 27 WARD)

2-FULL NAME ELBERTA SEXTON

(a) RESIDENCE. No. Belvedere Av-W-of-Roland- ST., 27 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 10 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSI- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates. OCCUPA-

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) June-27-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: William Elbert Sexton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Helen Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant (Address): Wm. Elbert Sexton, (father) Belvedere Av., City.

15 Filed JUL 8- 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 7, 1922, that I last saw her alive on July 7, 1922, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Unknown Disease

6 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Ruhräh, M. D.

July 8 1922 (Address) 11 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	July-8-22

20 UNDERTAKER STEWART & MOWEN COMPANY
WILLIAM F. WOOSER, Manager

ADDRESS 400 N. EUTAW AVE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 65797

CERTIFICATE OF DEATH.

K44

REGISTERED NO. D 65797

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Walter Joiner.

(a) RESIDENCE NO. Mercy Hospital ST., 4 WARD Chestertown Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? 63 yrs. 5 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Jan. 17 1859

7 AGE — Years: 63. Months: 5 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer. 086
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer: Self Chestertown

9 BIRTHPLACE (city or town) (State or country): Kent County Md.

PARENTS
10 NAME OF FATHER: Charles Joiner
11 BIRTHPLACE OF FATHER (city or town) (State or country): Chestertown Kent County Md.
12 MAIDEN NAME OF MOTHER: Maudie Nichols
13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Unknown

14 Informant (Address): Rwnds Mercy Hospital Baltimore Md

15 JUL 8-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-7-1922

17 I HEREBY CERTIFY, That I attended deceased from April 26. 1922. to July 7. 1922.
that I last saw h alive on July 7. 1922.
and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma Liver
Gall Bladder.
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgery (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 5-23-22
Was there an autopsy? No
What test confirmed diagnosis? Operative findings & microscopic report
(Signed) J. Bosley Ford M. D.
, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown - Md — DATE OF BURIAL: July 9 1922

20 UNDERTAKER: THOMAS F. KOONS, Assistant — ADDRESS: 108 W. NORTH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65798

HEALTH DEPARTMENT—CITY OF BALTIMORE

65798
D 65798

CERTIFICATE OF DEATH.

1/3

D 65798
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2708 Elliott St.; 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wicenty Jacomowicz

(a) RESIDENCE. No. 2708 Elliott St., 1 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 25-22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	12	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None yet

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md U S A

PARENTS

10 NAME OF FATHER Leon Jacomowicz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Martha Staniak

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Jacomowicz ~~Mother~~ Leon
(Address) 2708 Elliott St

15 Filed JUL 9- 1922 ROBERT R. KRAMER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922 to July 8, 1922, that I last saw him alive on July 7 1922, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) .... yrs. .... mos. 4 ds.

CONTRIBUTORY (Secondary) .... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl W Bohrer M. D.

July 8 1922 (Address) 1005 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	July 10 1922
20 UNDERTAKER	ADDRESS
J Stephen Jr Falkowski	1005 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65799 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 65799
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1721 Park Ave ST.: 14 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emma Clark

(a) RESIDENCE. No. 1721 Park Ave ST., 14 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? 74 yrs. 3 mos. 4 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Everett Clark

6 DATE OF BIRTH (month, day, and year): April-4-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS
10 NAME OF FATHER: Charles F. Bevan
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland
12 MAIDEN NAME OF MOTHER: Sarah Jane Carback
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs John E. Clark (Husband)
(Address) 1721 Park Ave

15 Filed JUL 9 - 1922 ROBERT R. KRAUER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July - 8 - 1922

17 I HEREBY CERTIFY, That I attended deceased from — , 1920, to July 8 , 1922.
that I last saw h alive on July 8 , 1922,
and that death occurred, on the date stated above, at 5,45 P. m.

The CAUSE OF DEATH* was as follows:
Angina pectoris

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis & Coronary Sclerosis (duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Edith Wan Nop, M. D.
7.8, 1922 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Lawn
DATE OF BURIAL: July 10 1922

20 UNDERTAKER: STEWART & BROWNE COMPANY
WILLIAM P. WOODEN, Successor
ADDRESS: 108 W. NORTH AVE

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.: 15 WARD)

REGISTERED No. C 161 D 65800

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Married Michener

(Residence in Baltimore: No. Woman's Hospital St.: 0 yrs., 0 mos. 5 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 3 (Day), 1922 (Year)

7-AGE, 0 yrs. 0 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles P. Michener

11-BIRTHPLACE OF FATHER (State or Country) Phila. Pa

12-MAIDEN NAME OF MOTHER Rena H. Klein

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. P. Michener (Father)

(Address) 3323 East Pratt St

15-

Filed JUL 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1922, to July 8 1922, that I saw her alive on July 8 1922, and that death occurred, on the date stated above, at 4 00 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) .... yrs. .... mos. 2 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) .... yrs. .... mos. .... ds.

(Signed) E. E. Duncan M. D.

7/8/22, 191... (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 5 ds. In the State 0 yrs. 0 mos. 5 ds.

Where was disease contracted, if not at place of death? Woman's Hosp.

Former or usual residence Woman's Hosp.

19-PLACE OF BURIAL OR REMOVAL, Linden Park Cem. DATE OF BURIAL, July 10, 1922

20-UNDERTAKER [redacted] HOWER [redacted] ADDRESS [redacted] LIBERTY AVE.

Remarks This baby was delivered by forceps. It cried spontaneously and in 4 days had regained its birth weight. Two days before death signs of intracranial haemorrhage appeared. It also showed many sub cutaneous haemorrhages and bled from the bowel. Lumbar and Sub occipital punctures showed bloody fluid. Ophthalmoscopic examination showed a haemorrhage sub dural haemorrhage. Autopsy showed a large clot between the two lateral hemispheres posteriorly.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21 M&T 1500 Bks.

Kreiling ✓ 122 B 02 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE B 65801

D 65801

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Creek Alley ST. 3 WARD)

2-FULL NAME August Kreiling

(a) RESIDENCE NO. 1005 Creek Alley ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Kreiling

6 DATE OF BIRTH (month, day, and year) July 7th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Pauline Kreiling (Address) 1005 Creek Alley

15 Filed JUL 9 - 1922 ROBERT R. KNAUER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20 1922 to July 7 1922.

that I last saw him alive on July 7 1922

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure.

(duration) ..... yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hayborn M. D.

7/8, 1922 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL July 10 1922

20 UNDERTAKER E. Schloman & Son — ADDRESS 1034 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates. This is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65802

D 65802

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N Stockton St. WARD) 18

2-FULL NAME Anthony Clifus Lee

(a) RESIDENCE. NO. 508 N. Stockton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Effie Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Lee (Address) 508 N. Stockton St.

15 Filed JUL 9 - 1922 ROBERT N. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to July 7, 1922, that I last saw him alive on July 7, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea and Enteritis

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Batteagem, M. D.

, 19 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery

DATE OF BURIAL July 10 1922

20 UNDERTAKER Wm. Katy R. Williams

ADDRESS 1114 N. Saratoga St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 65803

CERTIFICATE OF DEATH

1/3 D 65803

1 PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE (No. 3520 Chestnut Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George Gordon Culp

(Residence in Baltimore: No. 3520 Chestnut Ave St.; ... yrs. 6 mos. 7 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: July (Month) 8th (Day), 1922 (Year)

7 AGE: ... yrs. 6 mos. 7 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Louis Franklin Culp.

11 BIRTHPLACE OF FATHER (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary L. Shamberg

13 BIRTHPLACE OF MOTHER (State or country): York Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis F. Culp.

(Address) 3520 Chestnut Ave

15 Filed JUL 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 8th (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6th, 1922, to July 8th 1922, that I saw h— alive on July 8th, 1922, and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Acute intestinal intoxication

(Duration) ... yrs. ... mos. 2 ds

Contributory (SECONDARY) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) Francis Redwood M. D.

July 8th, 1922 (Address) 846 W 36th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Marys Hampden — DATE OF BURIAL: July 10, 1922

20 UNDERTAKER: Charnwith Sons — ADDRESS: Chestnut Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65804

CERTIFICATE OF DEATH.

74 D 65804

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 N. Broadway ST.; 8 WARD)

2-FULL NAME Samuel Stupfeld

(a) RESIDENCE. No. 1215 N. Broadway ST.; ..... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara L. Stupfeld

6 DATE OF BIRTH (month, day, and year) April 1 = 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick Stupfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clara L. Stupfeld
(Address) 1215 N. Broadway

15 Filed JUL 9 - 1922 ROBERT R. KNAUER, Registrar
Burial Permit Checked

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to July 8th, 1922, that I last saw him alive on July 8th, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

July 8, 1922 (Address) 1201 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 10 1922
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65805

CERTIFICATE OF DEATH.

D 65805

REGISTERED NO. 74-091

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3523 Reisterstown Road ST. 15 WARD)

2-FULL NAME Mary Lewis

(a) RESIDENCE. NO. 3523 Reisterstown Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lewis

6 DATE OF BIRTH (month, day, and year) April 8 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER Thos Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Mrs Albert Rosseberry
(Address) 3523 Reisterstown Road

15 Filed JUL 9 - 1922 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1922, to July 8 1922, that I last saw h alive on July 7 1922, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius W Shott M. D.

July 8, 19 22 (Address) 2067 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	July 10 1922

20 UNDERTAKER Wm L Black ADDRESS 927 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mc Greevy

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-22 65806

D 65806

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 Collins Ave. WARD 20)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget McGreevy

(a) RESIDENCE. NO. 313 Collins ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Patk McGreevy

6 DATE OF BIRTH (month, day, and year): — — 1844

7 AGE: Years 78 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Delia McGreevy

(Address) 313 Collins ave

15 Filed JUL 9- 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7 19 22

17

I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1922, to July 7, 1922,

that I last saw h ew alive on July 7, 1922,

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(No Paralysis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

July 9 22 (Address) Emmitsburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL 7/0 19 22

20 UNDERTAKER: J. F. Tracey & Sons — ADDRESS 1318 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65807

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

D 65807

CERTIFICATE OF DEATH.

14

REGISTERED NO. C.....

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Amanda D Sandsbury

(Residence in Baltimore: No. Ridgely Md St.; ..... yrs., ... mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, October (Month) 25 (Day), 1865 (Year)

7-AGE, 56 yrs. 8 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Hs

9-BIRTHPLACE, (State or Country), Caroline County Maryland

PARENTS.

10-NAME OF FATHER, James K. Sandsbury

11-BIRTHPLACE OF FATHER (State or Country), Caroline Co Md

12-MAIDEN NAME OF MOTHER Mary E. Gullett

13-BIRTHPLACE OF MOTHER (State or Country), Sussex Co Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma L. Sandsbury

(Address) Ridgely Md

15- Filed JUL 9 1922 191.... ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5 1922, to July 9 1922, that I saw h er alive on July 9 1922, and that death occurred, on the date stated above, at 9 58 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Ventral Hernia Post Operation

..... (Duration) 15 yrs. ..... mos. ..... ds.

(Signed) E E Duncan M. D.

July 9, 1922 (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 5 ds. In the State 56 yrs. 8 mos. 14 ds.

Where was disease contracted, if not at place of death? Ridgely Md.

Former or usual residence Ridgely Md.

19-PLACE OF BURIAL OR REMOVAL, Denton Caroline Co Md

DATE OF BURIAL, July 10, 1922

20-UNDERTAKER Henry A Jenkins Sons

ADDRESS McCulloh & Orchard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156796 D 65808

113 D 65808

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Forte

(a) RESIDENCE. NO. 1726 N Hilton St City WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Forte (Father),

6 DATE OF BIRTH (month, day, and year) ~~March~~ Feb 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Forte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Brocato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed JUL 9 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 7, 1922, that I last saw him alive on July 7, 1922, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery

(duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

7/1, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 7/10 1922

20 UNDERTAKER William Cook

ADDRESS 502 E North

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002

D 65809

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mitten

(a) RESIDENCE NO. 751 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5 If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Mitten

6 DATE OF BIRTH (month, day, and year) Nov 14 1883

7 AGE Years 39 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Danehey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John F. Mitten (Address) 751 W. Lexington

15 JUL 9-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8- 1922

17 I HEREBY CERTIFY, That I attended deceased from May 31- 1922, to July-8- 1922, that I last saw her alive on July 8- 1922, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Obstruction due to adhesions

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Paresis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 6-8-22

Did an operation precede death? Yes Date of 6-20-22

Was there an autopsy? no

What test confirmed diagnosis? Op. findings

(Signed) Newton D. Barr, M. D.

7/8/1922 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL 7/10 1922

20 UNDERTAKER Williams Cook ADDRESS 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 65810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 65810

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432-W-23 ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Gourley.

(a) RESIDENCE NO. 432-W-23 ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced (or) WIFE of Isabella Gourley

6 DATE OF BIRTH (month, day, and year) Apr. 2 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stonecutter

(b) General nature of Industry, business, or establishment in which employed (or employer) O'Connor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tipperary Scotland

PARENTS

10 NAME OF FATHER Robert Gourley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Mowatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Mrs.) Isabella Gourley

(Address) 432-W-23rd St.

15 Filed JUL 9-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922, to July 7, 1922, that I last saw h[illegible] alive on July 6, 1922, and that death occurred, on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Reeve J. G. Cross M. D.

July 7, 1922 (Address) 2438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL July 10, 1922

ADDRESS

20 UNDERTAKER Wm Coord, 502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state NAME EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Zuamenacek.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65811

D 65811

CERTIFICATE OF DEATH.

8 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2431 E Chase ST., 8 WARD)

2-FULL NAME Anthony Zimmermack.

(a) RESIDENCE No. 2431 E Chase ST., 8 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 78 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of Anna Zimmermack

6 DATE OF BIRTH (month, day, and year) May 17

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	78	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 088

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Zimmermack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Barbara Dobacek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant John Zuamenacek (Address) 2431 E Chase

15 JUL 9 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-1922

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to July 8, 1922, that I last saw him alive on July 8, 1922, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? —

(Signed) R. C. Herzog M. D., M. D.

1/8, 1922 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A.C. DATE OF BURIAL 7/11 1922

20 UNDERTAKER Wm Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be carefully classified. so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65812
D 65812

CERTIFICATE OF DEATH.

0 65812
161 D 65812
REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4190 Bel air Road ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Martin & Viola Doetzer

(Residence in Baltimore: No. 4190 Bel air Road St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... July (Month) 5 (Day), 1922 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. * ds.	5 hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Martin Doetzer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Viola Linton

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Linton Doetzer

(Address) 4190 Bel air Rd.

15-

Filed ..... 191 .....

JUL 10 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8 1922, to July 8 1922, that I saw h[illegible] alive on July 8 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Prematurity

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Claud Smith M. D.

July 9, 1922 (Address) 470 S. Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemetery

DATE OF BURIAL, July 10, 1922

20-UNDERTAKER Fred'k Cassebaum Sons

ADDRESS Fullerton Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN in every CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65813

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 131 D 65813 65813 65813

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Dickson

(a) RESIDENCE. (Usual place of abode) NO. Nazareth N. C. ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Robert Dickson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Elizabeth Godwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9- 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to July 9, 1922, that I last saw h[illegible] alive on July 9, 1922, and that death occurred, on the date stated above, at 11 05 a.m.

The CAUSE OF DEATH* was as follows:

Pyuria

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Extrophy of bladder

(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1, 1922

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Leo Brady, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Raleigh N. C.

DATE OF BURIAL 7/9/1922

20 UNDERTAKER H E Hughes 4th & N. Broadway

ADDRESS

N. B.—Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of information should be given. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

65814

HEALTH DEPARTMENT—CITY OF BALTIMORE

65814

D 65814

CERTIFICATE OF DEATH.

100 D 65814

REGISTERED NO. C.....

D 65814

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 Albemarle ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dominick Cofsollomi

(Residence in Baltimore: No. 31 Albemarle St. St.; 1 yrs., 8 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 30 (Day), 1920 (Year)

7-AGE, 1 yrs. 8 mos. 8 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... —
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Dominick Cofsollomi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Concetta Lozzie

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dominick Cofsollomi

(Address) 31 Albemarle

15- Filed JUL 10 1922 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4, 1922, to July 8, 1922; that I saw her alive on July 8, 1922; and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: 000

Broncho Pneumonia

(Duration) .....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Eugene L. Parsons M. D.

July 9, 1922 (Address) Govans

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, July 10, 1922

20-UNDERTAKER Wm. G. Schaeffer | ADDRESS 1816 Monument

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

65815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65815

CERTIFICATE OF DEATH.

D 65815

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Windsor Court Apts (ST.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis C. Schneidereith

(a) RESIDENCE. (No.) Windsor Court Apts (ST.) (WARD.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Schneidereith

6 DATE OF BIRTH (month, day, and year) May 23 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 863

(b) General nature of industry, business, or establishment in which employed (or employer) Commercial Printing

(c) Name of employer Sinnott

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. L. Schneidereith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E. Mrs. Schneidereith

(Address) 3537 Newland Ave

15 Filed ..., 19 ...

JUL 10 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8. 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to July 8, 1922.

That I last saw h... alive on July 8. 1922,

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

12 (duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm. Deetjen, M. D.

, 19 (Address) 1702 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 11. 1922

20 UNDERTAKER	ADDRESS
Mrs. John H. Snyder & Son	811 E. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 65816
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 Orleans ST., 6 WARD)

2-FULL NAME Sarah G. Pardoe

(a) RESIDENCE NO. 1911 Orleans ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE INFORMATION ASKED FOR IN THIS CERTIFICATE is required by law. Every question must be answered, or the certificate will be returned for correction. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Clifton N. Pardoe

6 DATE OF BIRTH (month, day, and year): Dec 26-70

7 AGE — Years: 51 — Months: 6 — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS
10 NAME OF FATHER: Henry C. Muir
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Annie J. —
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila.

14 Informant: Mrs E. Brasheares
(Address) 1911 Orleans St

15 Filed JUL 10 1922 19 GL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/8/ 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 20 1922 to July 8 1922
that I last saw her alive on July 7- 1922
and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Mic. at Hopkins

(Signed) Geo. Clinton Blades M. D.

7/9/22 (Address) 143 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 7/11 1922

20 UNDERTAKER: Philip J. Herwig — ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D 65817

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Niewiadowski)

CERTIFICATE OF DEATH.

113 D 65817

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S. Ross ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thadeus Niewiadowski

(a) RESIDENCE NO. 600 S. Ross. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 4 — 1921

7 AGE: Years 1; Months; Days 24; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 000

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Maximilian Niewiadowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Rojek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mary Niewiadowski (Address): 600 S Ross St

15 JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July - 7 - 1922, to July 8 — 1922, that I last saw h— alive on July 8 — 1922, and that death occurred, on the date stated above, at 6.15 p m.

The CAUSE OF DEATH* was as follows:

Status - Eclampsia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) [illegible] M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: July 10 1922

20 UNDERTAKER: Wm Faulkowski

ADDRESS: 1618 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65818

D 65818

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Reynolds ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. T. Oliver

(a) RESIDENCE. NO. 1424 Reynolds. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. E. Oliver.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Wm. E. Oliver.
(Address) 1424 Reynolds

15 Filed JUL 10 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 8, 1922, that I last saw h— alive on July 7, 1922, and that death occurred, on the date stated above, at 8 40 A. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm. T. Seabury, M. D.

7/9, 1922 (Address) 638 Fork

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	7/10 22
20 UNDERTAKER	ADDRESS
Williams Cook	502 E Mont

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65819

179 D 65819

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hospital St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William M Rinehart

(Residence in Baltimore: No. 429 West 23rd St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Sept (Month) 1 (Day) 1918 (Year)

7-AGE: 3 yrs. 10 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward N. Rinehart

11-BIRTHPLACE OF FATHER, (State or Country): Balto County

12-MAIDEN NAME OF MOTHER, Winifred Hamm

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward N. Rinehart

(Address) 429 West 23rd St

15-

Filed JUL 10 1922 192.. Registrar. GLG

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental - Burns from clothing ignited by match

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. S. H. Patterson M. D. (Coroner.)

7-9 192.. (Address) 508 E North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	7/10 1922
20-UNDERTAKER,	ADDRESS
William Cook	502 E North.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65820

CERTIFICATE OF DEATH.

31 D 65820

REGISTERED NO.

1-PLACE OF DEATH Municipal Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 18 WARD)

2-FULL NAME George Green

(a) RESIDENCE NO. 810 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 62 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hosp. Records

15 Filed JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5/1922

17 I HEREBY CERTIFY, That I attended deceased from 6-28 , 1922, to 7/5 , 1922, that I last saw him alive on 7/5 , 1922, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

7/5 1922 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL July 6 1922

20 UNDERTAKER Daniel Eerlans

ADDRESS Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65821

CERTIFICATE OF DEATH.

D 65821

90

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 940 N Howard St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Swift

(Residence in Baltimore: No. 940 N Howard St.; 25 yrs., X mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, DEC (Month) 14 (Day), 1863 (Year)

7-AGE, 58 yrs. 6 mos. 24 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph R. Swift

(Address) 940 N. Howard St

13-

Filed ....., 191.... Registrar.

JUL 10 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, JULY (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from JUN 9 1922 191.., to JUL 8 1922 191.., that I saw her alive on JUL 8 1922 191.., and that death occurred, on the date stated above, at 10-15 P m.

The CAUSE OF DEATH* was as follows:

Embolism of brain

.....

.....

.....

(Duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary) Endo-Carditis

(Duration) Unknown yrs. mos. ds.

(Signed) O. H. Duke M. D.

JUL 9 1922, 191.. (Address) 928 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Annapolis

19-PLACE OF BURIAL OR REMOVAL, Asbury Chapel

DATE OF BURIAL, July 10, 1922

20-UNDERTAKER David Easton

ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Attention to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65822

CERTIFICATE OF DEATH.

3 D 65822

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 839 S. Ellwood av ST.; 1 WARD.

2-FULL NAME William Lawrence O'Neill

(a) RESIDENCE. NO. 839 S. Ellwood av ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED 075

(a) Trade, profession or particular kind of work Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer) Drugs

(c) Name of employer John J. McGinley

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margt Gibbons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margt O'Neill
(Address) 839 S. Ellwood av

15 Filed JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1 1922 to July 6 1922

that I last saw h alive on July 6 1922

and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Wm. McAvoy, M. D.

7/7, 1922 (Address) 839 S. Ellwood av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL 7/10 1922

20 UNDERTAKER J. A. Moran ADDRESS 3000 E Balto.

N. B.—WRITE PLAINLY with pen and ink. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65823

CERTIFICATE OF DEATH.

101 001

D 65823

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1073 W. Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sunny Boy Hall

(Residence in Baltimore: No. 1073 W Lexington St.; yrs. 6 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, January 1, 1922 (Month) (Day) (Year)

7-AGE, yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Robt Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hall

(Address) 1073 W Lexington St

15-

Filed....., 191.....

Registrar.

JUL 10 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1922, to July 8 1922, that I saw him alive on July 1922, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Gas. Poisoning

(Duration) yrs. mos. 8 ds.

(Signed) C. H. Flowar M. D.

July 8, 1922 (Address) 742 S. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL. July 10, 1922

20-UNDERTAKER J. Bernard Tilp and Schenck

ADDRESS 114 N.

N.B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stec.—6-9-19—H. P. Co.—1000 Bks.

D 65824 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65824

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N Fremont ST. 16 WARD)

2-FULL NAME Harvey R Watkins.

(a) RESIDENCE. NO. 608 N Fremont ST., — WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
—	—	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ooo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 608 N Fremont Ave Balto Md

PARENTS

10 NAME OF FATHER H R Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ina Abey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant H R Watkins (Address) 608 N Fremont Ave

15 Filed JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July-4 . 1922 to July-8.- . 1922.

that I last saw him alive on July 8 — . 1922.

and that death occurred, on the date stated above, at 9.8, m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia + Ileo-colitis.

(duration) yrs. — mos. 6, ds.

CONTRIBUTORY (Secondary) — Respir failure

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Consult- Dr Little.

(Signed) Wesley Cole, M. D.

7/9, 1922 (Address) 2707 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL July 10 1922

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

N. B.—WHITE PAPER, BLACK INK. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65825

D 65825

CERTIFICATE OF DEATH.

164

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Shuter ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eunice M Moore

(Residence in Baltimore: No. 805 Shuter st St.; 30 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, ~~July~~ Unknown ~~8~~ ....., ~~1922~~ (Month) (Day) (Year)

7-AGE, 67 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Servant
(b) General nature of industry, business, or establishment in which employed (or employer)..... D74

9-BIRTHPLACE, (State or Country), not known

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruthie Pittington

(Address) 805 Shuter St

15- FILED JUL 10 1922, 191..... Registrar.

JUL 10 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 28 1922, to July 8 1922, that I saw her alive on July 8 1922, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration).....yrs.....mos.....ds.

Exhaustion

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Wm S Gage M. D.

July 11 22, 191... (Address) 706 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, National Cem

DATE OF BURIAL, July 11, 1922

20-UNDERTAKER Jno Robert & Ellicott

ADDRESS 1723 Ashland Ave

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec. 6-90 [illegible] 1000 Bks.

D 65826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 65826

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 S Spring st ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Johnson

(a) RESIDENCE. No. 1520 Bolton street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 03 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lillian May Johnson

6 DATE OF BIRTH (month, day, and year) March 3-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 173

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Atlantic Ice Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Lillian Johnson (Address) 18 S Spring St.

15 Filed JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to —, 19—, that I last saw h[illegible] alive on June 25, 1922, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Saml Sugar, M. D.

, 19 (Address) 32 So. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	July 13 1922

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Oakland Ave

NOTE—Items 1 to 15 must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65827

CERTIFICATE OF DEATH.

D 65827

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 307 N Gilmore ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Jones

(Residence in Baltimore: No. 307 N Gilmore St.) 80 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct (Month) ..... (Day), 1880 (Year)

7-AGE, 41 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James Haywood

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Husband

(Address) 307 Gilmore

15-

Filed JUL 10 1922 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner (Coroner, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture of Coronary Artery (Duration) 2nd days yrs. mos. ds.

(Signed) James H. Preston M. D.

July 8 1922 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, July 11 1922

20-UNDERTAKER Lawrence Dwyer ADDRESS 364 W Conway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65828

74 D 65828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 N Gay ST. 8 WARD)

2-FULL NAME Emma V. Roberts

(a) RESIDENCE No. 1200 N Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1843

7 AGE Years 79 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Arthur Moffett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Stevens

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Mrs Sarah E Bright

(Address) 1200 N Gay St

15 Filed JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 7, 1922, that I last saw her alive on July 7, 1922 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

1 Chronic Gastritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Microscopic

(Signed) Geo F Taylor M. D.

July 29, 1922 (Address) 1263 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 10 1922

20 UNDERTAKER Robt J Turner Sr ADDRESS 1142 N Broadway

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65829

CERTIFICATE OF DEATH.

46

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1635 Jefferson ST., 6 WARD)

2-FULL NAME Margaret M Ritchie

(a) RESIDENCE NO. 1635 Jefferson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE LEGIBLY. Use ink. Do not use lead pencil. All items must be answered or "unknown" or "none" inserted where necessary. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Ritchie

6 DATE OF BIRTH (month, day, and year): June 10 1871

7 AGE: Years 51 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Walter Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Laura Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Samuel Ritchie

(Address): 1635 Jefferson St

15 Filed: JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 8, 1922,

that I last saw her alive on July 7, 1922,

and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Cervix

(duration) ..... yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary) + Lung Metastases to glands.

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pieces from Cervix

(Signed) Hiram Howard, M. D.

, 19 (Address) 913 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount.

DATE OF BURIAL: July 10 1922

20 UNDERTAKER: Robt L Turner

ADDRESS 1442 N Broadway

D 65830

D [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65830

D [redacted]

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hop. St., 15 Ward) 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Alice Young

(Residence in Baltimore: No. 1616 Presstman St.; yrs. 20 mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH. about ..... (Month) ..... (Day) 1902 (Year)

7-AGE, 20 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 170

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER, (State or Country). [illegible]

12-MAIDEN NAME OF MOTHER, [illegible]

13-BIRTHPLACE OF MOTHER, (State or Country). [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. Dennis

(Address) 1303 Brookmont,

15- Filed JUL 20 1922 19.. [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 5 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of chest (Duration and death)

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Stomach trouble

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

July 5 1922 (Address) 25 E. Lexington St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, July 9 1922

20-UNDERTAKER, Samuel A. Adams | ADDRESS, 1313 Greenmount

Spec.—8-24-14—M. & T.—2000 Bks.

D 65831 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65831

CERTIFICATE OF DEATH

58-001

1-PLACE OF DEATH Women's Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette & Johns St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth C. Hewson

(Residence in Baltimore: No. 506 E. 23rd St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, 12 (Month) 31 (Day), 1877 (Year)

7-AGE, 45 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Typist
(b) General nature of industry, business, or establishment in which employed (or employer) Md

9-BIRTHPLACE, (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER, George Hewson

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Aurora Cullen

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leda M. Hewson

(Address) 506 E 23rd St.

15- Filed JUL 10 1922, 191.... Registrar. I.A.W.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 7 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 30 1922, to July 7-8 1922 that I saw her alive on July 7-8 1922 and that death occurred, on the date stated above, at 12.40 P.M.

The CAUSE OF DEATH* was as follows:

Respiratory failure

(Duration), ...yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(Duration) 2 yrs. ....mos. ....ds.

(Signed) R. H. Slaughter M. D.

7-8, 1922 (Address) Women's Hosp City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 41 ds. In the State 50 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 506 E 23rd St City.

19-PLACE OF BURIAL OR REMOVAL, St Joseph's Cemetery DATE OF BURIAL, July 11, 1922.

20-UNDERTAKER Henry H. Jenkins Son Co ADDRESS Orchard & Gay Caton St

N.B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

√D 65832

D 65832 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

134-002

REGISTERED NO.

1-PLACE OF DEATH Municipal Hosp 3 ST., 17 WARD)

CITY OF BALTIMORE, No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Levy

(a) RESIDENCE NO. 1215 Argyle ST., WARD

(Usual place of abode) about 40 (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE LEGIBLY, with ink. All questions must be answered, or "unknown" stated. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1858

7 AGE Years 64 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) Camden S.C.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Hosp Records

(Address) Hosp

15 Filed JUL 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7-1922

17 I HEREBY CERTIFY, That I attended deceased from 7-6-1922 to 7-7-1922

that I last saw him alive on 7-6-1922

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Urinary infiltration

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Renal insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address) 7-7-1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden S.C.

DATE OF BURIAL July 1922

20 UNDERTAKER Samuel Herndon Biddle

ADDRESS 578

67

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65833

CERTIFICATE OF DEATH.

D 65833

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Lewis McDermott

(a) RESIDENCE. NO. 1920 Ridgewood Ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23rd 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. T. McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel L. Redifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed JUL 10 1922 H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24th, 1922, to July 8th, 1922, that I last saw him alive on July 8th, 1922, and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Birth Injury (Cerebral hemorrhage).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

7/8, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL July 10 1922

20 UNDERTAKER Isaiah Syfer ADDRESS 1600 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If under one day, the number of hours or minutes should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—4-10-21—M&T—1500 Bks.

D 65834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65834

88

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3926 Fait ave ST., 1 WARD)

2-FULL NAME Kate L. Rau

(a) RESIDENCE NO. 3926 Fait ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Chas. F. W. Rau

6 DATE OF BIRTH (month, day, and year) Nov. 18. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.,
(State or country) Md.

PARENTS

10 NAME OF FATHER Adam Lohr

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Koster

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Chas F. W. Rau
(Address) 3926 Fait ave

15 Filed JUL 10 1922, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1st 19 22, to July 8 19 22,

that I last saw h.. alive on July 7 19 22, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cellulitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Sign

(Signed) F. Wiesmann M. D.

1919 Fait Ave 19 22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL July 11 1922

20 UNDERTAKER Sirkler + Sirkler

ADDRESS 1739 E. Eager

N. B.—WRITE PLAINLY. All information carefully supplied. AGE should be carefully supplied. PHYSICIANS and State mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and State mation should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65835

CERTIFICATE OF DEATH.

44

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Callow ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Plimack

(Residence in Baltimore: No. 2211 Callow ave St.: 25 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1868
(Month) (Day) (Year)

7-AGE, 54 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clothing
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Tailor

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Nathan Plimack

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. .....

(Address) 1439 E. Baltimore St.

15- Filed JUL 10 1922, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1921, to July 9 1922,
that I saw h im alive on ....., 1922,
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

..... (Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A. J. Friedman M. D.

7/10 22, 191... (Address) 918 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Rodeph Shalom	July 10, 1922
20-UNDERTAKER	ADDRESS
East Lewis	1439 E Balto

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65836

D 65836

CERTIFICATE OF DEATH.

REGISTERED NO. C 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John George Wolak

(Residence in Baltimore: No. 720 S. Ann St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, November (Month) 15 (Day), 1920 (Year)

7-AGE, 1 yrs. 7 mos. 23 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Wolak

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Julia Zielinska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wolak

(Address) 720 S. Ann St.

15-

Filed JUL 10 1922 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 24 1922, to July 8 1922, that I saw h[illegible] alive on July 8 1922, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

.....

.....

Pneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Steph. J. Lewandowski M. D.

7-9-, 1922 (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	July 10, 1922

20-UNDERTAKER John Mader ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. Not CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

...rly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Blks.

D 65837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65837

CERTIFICATE OF DEATH.

6 113

REGISTERED NO. 6491

1-PLACE OF DEATH Balto Md

CITY OF BALTIMORE: (No. 209 Harrings Court ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Weeks

(a) RESIDENCE NO. 209 Harrings Court ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Frizzel Weeks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Hampton Co Va

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Camargo Md

14 Informant Edward Turner
(Address) 209 Harrings Court

15 Filed JUL 10 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1922, to July 9, 1922, that I last saw her alive on July 8, 1922, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhea (summer) and Colic

(duration) yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) convulsions & collapse

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no of stools.

What test confirmed diagnosis? frequency & character

(Signed) M M Patterman, M. D.

7/10, 1922 (Address) 1627 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL July 10 1922

20 UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65838

D 65838

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Murray

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Patrick Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records, Municipal Hospital

15 Filed JUL 10 1922 J.H. Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to July 8, 1922, that I last saw him alive on July 7, 1922, and that death occurred, on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) / yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Clyde McNeill M. D.

7/10/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL July 10 1922

20 UNDERTAKER Easton Sons — ADDRESS Elliott & 6th

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

17 12 - Bethel st ✓

Spec.—1-10-21—M&T—1500 Bks.

D 65839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65839

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Municipal Hospitals

CITY OF BALTIMORE: No. 17 1/2 Bethel ST., 8 WARD)

2-FULL NAME John F. Beran

(a) RESIDENCE NO. 17 1/2 N. Bethel ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs M. Beran

6 DATE OF BIRTH (month, day, and year) March 15. 92

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter 059
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER John Beran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Mrs. Reed

15 Filed JUL 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7/1922

17 I HEREBY CERTIFY, That I attended deceased from 5-22-1922 to 7/7/1922

that I last saw him alive on 7/7/1922

and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Glioma ? Brain, recurrent

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of J. Hopkins

Was there an autopsy? Yes What test confirmed diagnosis? Aut. + Operation

(Signed) Clyde McNeil, M. D.

7/8, 1922 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL July 11 1922

20 UNDERTAKER Geo. F. Roth ADDRESS 735 Harford Ave.

N. B.—WRITE PLAINLY. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65840

CERTIFICATE OF DEATH.

3 | D 65840

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Brown

(Residence in Baltimore: No. 2009 McCulloh St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, September (Month) 7.1 (Day), 1876 (Year)

7-AGE, 45 yrs., 9 mos., 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer): 886

9-BIRTHPLACE, (State or Country), Baltimor Maryland

PARENTS.

10-NAME OF FATHER, John Brown

11-BIRTHPLACE OF FATHER (State or Country), Accomac Co Va

12-MAIDEN NAME OF MOTHER Hariatt A Toyton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimor County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella L Brown

(Address) 2009 Mc Culloh St

15-

Filed....., 191.....

JUL 10 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25th 1922, to July 8th 1922, that I saw h.. alive on July 8th 1922, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. J. Keller M. D.

July 8th, 1922 (Address) 220 W Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, 7/11, 1922

20-UNDERTAKER James N Deaver Jr

ADDRESS 2007 Mc Culloh

N. B.—Every item of information must be carefully supplied. Exact statement of OCCUPATION is only CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65841 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65841

CERTIFICATE OF DEATH.

160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Curtis Ave. Curtis Bay ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Harrison Carryer

(a) RESIDENCE NO. 1511 Curtis Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 3rd '22.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) Curtis Bay (State or country) Md.

PARENTS

10 NAME OF FATHER Harry B. Carryer

11 BIRTHPLACE OF FATHER (city or town) Buffington (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Esther May Loudon

13 BIRTHPLACE OF MOTHER (city or town) Jefferson Co. (State or country) W. Va.

14 Informant Harry B. Carryer (Address) 1511 Curtis Ave Balto.

15 Filed JUL 10 1922, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to July 8, 1922, that I last saw him alive on July 6, 1922, and that death occurred, on the date stated above at 5 a. m.

The CAUSE OF DEATH* was as follows:

Inanition — Hereditary weakness and improper feeding. (Mother tubercular)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. B. Davis, M. D.

7/8, 1922 (Address) 211 Church St. - Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] HOSPITAL DATE OF BURIAL JUL 10 1922

20 UNDERTAKER [illegible] ADDRESS

JOHNS HOPKINS Health Commissioner

[illegible] E. WOODALL

N. B.—Certificates should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65842 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65842

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ... ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Krause

(a) RESIDENCE. NO. 127 Rochester Place ST. ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emanuel Krause

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 74 | Months 3 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Krause

(Address) 127 Rochester Place

15 Filed JUL 10 1922 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to July 7, 1922

that I last saw h[illegible] alive on July 7, 1922

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) J. Knott Insley, M. D.

7-9-22 (Address) 2938 E. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mathews Cemetery — DATE OF BURIAL: 7/10/22

20 UNDERTAKER: J. G. Moran — ADDRESS 3[illegible] E Balto

Spec.—1-10-21—M&T—1500 Bks.

D 65843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65843

CERTIFICATE OF DEATH.

X 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Hollins ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Harrison

(a) RESIDENCE NO. 825 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. / mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 — 1922

7 AGE — Years | Months: 6 | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER Roland Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md.

12 MAIDEN NAME OF MOTHER Mildred Mowbray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant John W. Pitcher (Address) 2613 E. Blain Ave.

15 Filed JUL 10 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6th, 1922, to July 9th, 1922, that I last saw her alive on July 8th, 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. one mos ds.

CONTRIBUTORY (Secondary) General asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms only

(Signed) W. H. Klaucke, M. D.

19 (Address) 1812 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 10-22

20 UNDERTAKER: Wm. C. Miller — ADDRESS: 2334 Jeffer[illegible]

N. B.—WRITE PLAINLY, with permanent ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65844

CERTIFICATE OF DEATH.

D 65844

REGISTERED NO. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1161 Hanlsecke St.; 21 WARD)

2-FULL NAME Frank Hunter Jr.

(a) RESIDENCE NO. 1161 Hanlsecke ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. Information supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): July 9-1922

7 AGE: Years | Months | Days | If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mildred Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Jacob Troeger

(Address): 1161 Hanlsecke St

15 Filed JUL 10 1922 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/9/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/9/22, 19..., to 7/9/22, 19...,

that I last saw h... alive on 7/9/22, 19, at 7:30P m.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Failure Circumscribe Oedema to Glottis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maryland Dreer, M. D.

, 19 (Address) 19 E Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: July 10 1922

20 UNDERTAKER: Lowe Cook & E Kaufman — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 65845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65845

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 N. Henry ST., 20 WARD)

2-FULL NAME Conrad Schelle

(a) RESIDENCE NO. 2007 N. Henry ST. 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia H. Schelle

6 DATE OF BIRTH (month, day, and year): July 4-1847

7 AGE: Years 75 | Months — | Days 4 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer): B. My & R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Amelia Schelle

(Address) 2007 N. Henry St

15 Filed JUL 10 1922 ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1922, to July 8, 1922, that I last saw him alive on July 7, 1922, and that death occurred, on the date stated above, at 3 A m.

THE CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Howard W. Jones M. D.

7-9 1922 (Address) Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: July 11 1922

20 UNDERTAKER: H. B. Hesselbrock

ADDRESS: 2216 Druid Hill Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 65846

HEALTH DEPARTMENT—CITY OF BALTIMORE

165 D 65846

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2783 Wilkens ave St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise M. Shores

(Residence in Baltimore: No. 2783 Wilkens ave St.; yrs. 53 mos. 10 ds. 22)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Aug (Month) 31 (Day) 1868 (Year)

7-AGE: 53 yrs. 10 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balto City.

PARENTS.

10-NAME OF FATHER: August Will

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Voigts

13-BIRTHPLACE OF MOTHER, (State or Country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose M. Lentz

(Address) 2770 Wilkens ave

15- Filed JUL 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pleural Poisoning

Caused while insane

(Duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Melancholia

(Duration) yrs. 4 mos. ds.

(Signed) James M. Fenton M. D. (Coroner.)

July 10 1922 (Address) 700 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery DATE OF BURIAL July 12 1922

UNDERTAKER, H. B. Kuppert ADDRESS 2236 Frederick Ave

N. B.—Every item of information should be carefully supplied. Age should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65847

D 65847

46

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Balt. Gen Hospital.

CITY OF BALTIMORE: (No. 1213 Light St. ST., 9 WARD) A

2-FULL NAME Louise A. Bubert.

(a) RESIDENCE NO. 2315 Taylor ST., 9th WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

5a If married, widowed, or divorced (or) ~~HUSBAND OF~~ WIFE of Bernard M Bubert.

6 DATE OF BIRTH (month, day, and year) April, 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	31	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Koubek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe.

14 Informant Bernard M. Bubert

(Address) 2315 Taylor Ave

15 Filed JUL 10 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2 1922 to July 8 1922, that I last saw her alive on July 5 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix s operation: surgical shock

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Shock (surgical)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of July 5. 22

Was there an autopsy? No

What test confirmed diagnosis? palpation + microscopic

(Signed) [illegible] M. D.

, 19 (Address) 827 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL July 11 1922

20 UNDERTAKER [illegible]

ADDRESS 1966 Park Ave

N. B.—WRITE LEGIBLY. Only Spaces provided should be filled in. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65848

CERTIFICATE OF DEATH.

46 D 65848

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 735 Cumberland St., 15 WARD)

2-FULL NAME Bessie May Williams

(a) RESIDENCE NO. No. 735 Cumberland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Williams

6 DATE OF BIRTH (month, day, and year) Mch 20 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER John Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md.

12 MAIDEN NAME OF MOTHER Ella A Rowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant William J. Williams (Address) 735 Cumberland St.

15 Filed JUL 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1922, to July 9, 1922, that I last saw her alive on July 9, 1922, and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) Some 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxaemia - Exhaustion

(duration) - yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 6 mos ago

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Mifflin, M. D.

7/10, 1922 (Address) No. 1016 Mad. Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemet — DATE OF BURIAL July 12 1922

20 UNDERTAKER Williams Cook — ADDRESS 507 N Howard St

N. B.—WRITE LEGIBLY. All questions must be carefully answered and if information is not supplied, the reason should be stated. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65849

X 33

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sidney A. Fowler

(a) RESIDENCE NO. Whitestone Va ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ——— yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 9 1875

7 AGE — Years: 47 Months: 2 Days: 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Davidson Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Cowdins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Mrs Carrie McGinnis 410 E. Lafayette Ave

15 Filed JUL 10 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30 1922 to July 10 1922

that I last saw her alive on July 10, 1922

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis.

(duration) yrs. 2/12 mos ds.

CONTRIBUTORY (Secondary): Cachexia

(duration) yrs. 1/2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-3-22

Was there an autopsy? No.

What test confirmed diagnosis? Operation findings

(Signed) H. J. Essig M.D.

19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL: Whitestone Va — DATE OF BURIAL: July 11 1922

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

X. B.—WRITE plainly, preferably with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65850

CERTIFICATE OF DEATH.

90 D 65850

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 652 Redwood st St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ellis Kusick

(Residence in Baltimore: No. 652 Redwood St (yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
45 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Steel

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Joseph Kusick

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Balchunes

(Address) 652 Redwood St

15- Filed JUL 10 1922 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ~~Inquest, or~~ Inquiry.) find that said deceased came to Hys death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D.

(Coroner)

7-10 1922 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel DATE OF BURIAL. July 11 1922

20-UNDERTAKER. Geo Lewis & Co ADDRESS 647 W Pratt

N. B.—Every item of information should be carefully supplied. Age should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65851

CERTIFICATE OF DEATH.

D 65851

REGISTERED NO. C 117

1-PLACE OF DEATH Woman's Hospital.

CITY OF BALTIMORE: (No. 14 ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tressa May Burg Bowersox

(Residence in Baltimore: No. Westminster Md. St.: ..... yrs., mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	married

6-DATE OF BIRTH, August (Month) 3 (Day), 1902? (Year)

7-AGE, 20 yrs. 11 mos. 7 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE, (State or Country) East Prospect Penna.

PARENTS.

10-NAME OF FATHER, Moses Abraham Burg

11-BIRTHPLACE OF FATHER (State or Country), York County, Penna

12-MAIDEN NAME OF MOTHER ~~Tressa May~~ Lizzie Burg

13-BIRTHPLACE OF MOTHER (State or Country), York County, Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John D. Bowersox

(Address) 102 Penn ave

15- Westminster, Md.

Filed JUL 10 1922 ROBERT R. KRAETER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1922, to July 10 1922, that I saw her alive on July 10 1922, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

following acute Dilatation of Stomach

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Abandectomy for Chronic appendicitis and Cholelithiasis and Cholecystitis (Duration) ..... yrs. ? mos. ..... ds.

(Signed) C. Addison Gan M. D.

July 10, 1922 (Address) Woman's Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westminster Md

DATE OF BURIAL, July 13, 1922

20-UNDERTAKER W. M. Rouston

ADDRESS 223 N. Mathews

N. B.—Every item of information should be carefully considered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65852

CERTIFICATE OF DEATH.

D 65852

139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Henrietta Waldorf

(a) RESIDENCE NO. 2300 Madison Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 6 1884

7 AGE: Years 38 yrs. Months 6 Days 2. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Moses Waldorf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Trefz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry Waldorf (Address) 2300 Madison Ave.

15 Filed JUL 10 1922 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July. 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to July 9, 1922, that I last saw h[illegible] alive on July 9, 1922, and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Uterine fibroid

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-30-22

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) J. Chaoyno, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: July 10th 1922

20 UNDERTAKER: David Sondheim ADDRESS: 118 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. D 65853

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Henry Fortnaw

(Residence in Baltimore: No. 3753 Cottage Ave St.; yrs. abt 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept. (Month) 2 (Day) 1896 (Year)

7-AGE. 25 yrs. 11 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country) Dublin - Ireland

PARENTS.

10-NAME OF FATHER. David Freeman

11-BIRTHPLACE OF FATHER. (State or Country) Dublin, Ireland

12-MAIDEN NAME OF MOTHER. Annie Greenfield

13-BIRTHPLACE OF MOTHER. (State or Country) Dublin Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Hess

(Address) 3461 Cottage Ave

15- Filed JUL 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 9 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. 1/2 mos. 5 ds.

CONTRIBUTORY (Secondary)

(Signed) Geo. Colton Bland (Coroner) M. D.

(Address) 1432 E. Pray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Balto. Heb. Cem.	7/11/1922
20-UNDERTAKER. Isaac Sondheim	ADDRESS. 1118 N. Mt. Royal Ave.

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65854

CERTIFICATE OF DEATH.

113 D 65854

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Hull ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Sylvester

(a) RESIDENCE. No. 1115 Hull ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Sylvester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Wojciechowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Sylvester (Address) 1115 Hull

15 Filed JUL 10 1922 ROBERT R. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to July 9, 1922, that I last saw her alive on July 9, 1922, and that death occurred, on the date stated above, at 11 50 a.m.

The CAUSE OF DEATH* was as follows:

acute Phlegmonous Colitis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis Taylor M. D.

7/10, 1922 (Address) 243 Hull

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 11 1922

20 UNDERTAKER ADDRESS

John M. Weber 1803 Bank St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Kropowicz

113 D 65855

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2423 (ST.:) Pfister Ct (WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wadaw Kropowicz

(a) RESIDENCE. No. 2423 Pfister Ct ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wadaw Kropowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Szymanska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Buffalo New York

14 Informant Mary Kropowicz
(Address) 2423 Pfister Ct

15 Filed JUL 10 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9 1922, 19, to July 10 1922, 19, that I last saw h alive on July 10 1922, 19, and that death occurred, on the date stated above, at 430 P m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dialysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A Williams M Gaertner, M. D.

19 (Address) July 10 1922 1 Revere Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 11 1922

20 UNDERTAKER	ADDRESS
John A Weber	1825 Bank St

NOTICE—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65856 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65856

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Archer ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Dyer

(a) RESIDENCE. NO. 522 Archer ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Dyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant David Easton
(Address) 916 Pa Ave

15 Filed JUL 11 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 9, 1922, that I last saw him alive on July 8, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Articular Rheum

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Morley Strong, M. D.

7/9, 1922 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	July 11 1922

20 UNDERTAKER David Easton ADDRESS 916 Pa Ave

mation should be carefully supplied. AGE should be stated EXACTLY. THE DISEASE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Reported as pulmonary tuberculosis Phipps' Dispensary. (Physician) states may possibly Dr. Hoag tuberculosis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

001

74 D 65857

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Biddle ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Taylor James

(a) RESIDENCE. No. 519 Burke St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie James

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. J. Flannigan & Co

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Daniel Easton

(Address) 916 Eutaw

15 Filed JUL 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

t6 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to July 8, 1922, that I last saw him alive on July 8, 1922, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

t8 Where was disease contracted if not at place of death? 519 Burke St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yours

(Signed) John R Deaver, M. D.

, 19 (Address) 753 Georges St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 11 22

20 UNDERTAKER Daniel Easton & Co ADDRESS 916

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65858

CERTIFICATE OF DEATH.

D 65858

REGISTERED NO. 31

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) Municipal Tbc. Hosp. (ST.) 17 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Gowers

(a) RESIDENCE. NO. 1515 Baseley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work O&D
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkridge Md.

PARENTS
10 NAME OF FATHER Samuel Gowers
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Eliz. Vibary
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Hosp. Records

15 Filed JUL 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from March 12 1922, to July 8th 1922,
that I last saw him alive on July 8th 1922,
and that death occurred, on the date stated above, at 2 50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum, Urine & Autopsy

(Signed) Frances L. Dadaglieri, M. D.

, 19 (Address) Municipal Tbc Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 11 1922
UNDERTAKER	ADDRESS
Jno A. Hooper	401 N Conway

mation should be carefully supplied. AGE should be stated IMMEDIATELY after NAME. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65859

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Windsor Court Apts. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvina T. Walter

(Residence in Baltimore: No. Windsor Court Apts St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ...March...., 1 .....
(Month) (Day) (Year)

7-AGE, 62 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....None....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Jas W. A Mayo

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Miller

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....Leonard Waller....

(Address) ....Cloverdale Rd....

15-

Filed JUL 11 1922 ....E. L. G.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1921 to July 9 1922, that I saw h[illegible] alive on July 9 1922, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(Duration) ....yrs. 3 mos. ....ds.

(Signed) Henry M. Stiff M. D.

July 10 1922 (Address) 2430 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, ..., 191...

20-UNDERTAKER, Jno L Dabney

ADDRESS 1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 65860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65860

CERTIFICATE OF DEATH.

REGISTERED NO. 100,091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hackett

(a) RESIDENCE. NO. Unknown ST., WARD.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital

15 Filed JUL 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from January 5, 1905 to July 10, 1922.

that I last saw her alive on July 9, 1922.

and that death occurred, on the date stated above, at 6:50 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/10/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 11 1922
20 UNDERTAKER	ADDRESS
John H. Owens	5-38 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 65861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65861

CERTIFICATE OF DEATH.

5-33

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1411 Mc Elderry St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Hall

(Residence in Baltimore: No. 1411 Mc Elderry St.; yrs. 5 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	

6-DATE OF BIRTH. July (Month) 14 (Day) 1922 (Year)

7-AGE. 0 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), —

12-MAIDEN NAME OF MOTHER, Virginie Hall

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Rosa Hall

(Address). 1411 Mc Elderry St

15-

JUL 11 1922 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mal Nutrition

Marasmus

(Marasmus Tuberculosis)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Gastro-Intestinal

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Fallen M. D.
(Coroner.)

July 11 1922 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Asbury Cemetery

DATE OF BURIAL. July 11 1922

20-UNDERTAKER. C. C. Goss

ADDRESS 1405 Mc Elderry St

N. B.—Every item of information called for should be given, so that it may be properly classified. Exact statement of OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65862

D 65862

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 N. Regester St. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet. J. Niblett

(a) RESIDENCE NO. 1605 N. Regester ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The late John. W. Niblett

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
	About 73	-----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Mr. Killmond

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Mr. Albert. C. Niblett

(Address) 1605 N. Regester

15 Filed JUL 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-10-1922

17 I HEREBY CERTIFY, That I attended deceased from April, 1922, to July 10, 1922, that I last saw her alive on July 10 8 P. M. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paraplegia 1 Myocarditis & Arteriosclerosis

Incontinent and urine

(duration) Paraplegia yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis & Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Paraplegia at 1605 N Regester

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms & Course from the time

(Signed) R. J. Carman, M. D.

7-11, 1922 (Address) 1201 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July-13-1922

20 UNDERTAKER Henry Hoch & Son

ADDRESS 1301 E Lafayette

N. B. ... should be carefully supplied. AGE should be stated EXACTLY. OCCUPATIONS must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65863 ✓ 65863

CERTIFICATE OF DEATH.

REGISTERED NO. 15-113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Lorman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Weston

(a) RESIDENCE. NO. 1824 Lorman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Weston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Margaret Weston (Address) 1824 Lorman St.

15 Registrar Ham

JUL 11 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1922 to July 9, 1922

that I last saw him alive on July 9, 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Quinn M. D.

July 10, 1922 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 12 1922

20 UNDERTAKER Edward Ruggola — ADDRESS 1463 Hanover

mation should be carefully supplied. Exact statement of OCCUPA-
may be properly classified.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65864

65864

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH U.S.V.HOSP.#56-

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dan Gzdi

(a) RESIDENCE NO. 864 W.Fayette St.Balto.Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) --

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steem Fitter 060

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Roumania

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) --

12 MAIDEN NAME OF MOTHER ---

13 BIRTHPLACE OF MOTHER (city or town) (State or country) --

14 Informant HOSPITAL RECORDS,
(Address) Ft.McHenry,Md.

15 Filed JUL 11 1922. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to July 8 1922.

that I last saw him alive on July 8, 1922,

and that death occurred, on the date stated above, at 3:40 pm.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Empyema, left chest

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of --

Was there an autopsy? No & Laboratory

What test confirmed diagnosis? Clinical Reports

Gen. O.P. (Signed) [signature] M. D.

7/8/22 (Address) SURGEON(R) U.S.V.Hosp.#56, Ft.McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL July 11 1922

20 UNDERTAKER A. Leivson & Bro — ADDRESS 127 E. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 65865 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65865

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 601 N. Calhoun St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Foos

(Residence in Baltimore: No. 601 N. Calhoun St. St.; yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	widow

6-DATE OF BIRTH. about ....., 1857 (Month) (Day) (Year)

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home duties
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. Schaffer

(Address) 601 N. Calhoun St.

15- Filed JUL 11 1922 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyaemia Lean Uterus

(Duration) yrs. mos. (one) 7 (seven) ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. F. Hennessy M. D. (Coroner.)

July 11 1922 (Address) 2702 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	July 11 1922
20-UNDERTAKER, C. W. Dill	ADDRESS 3784 Fredk. ave.

N. B.—Every item of information should be given if possible. It may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 65866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65866

CERTIFICATE OF DEATH.

77

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3827 Reisterstown St., 15 WARD)

2-FULL NAME Julia Ford Eubank

(a) RESIDENCE NO. 3827 Reisterstown Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ——— 000

(c) Name of employer ———

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Thom T. Eubank

11 BIRTHPLACE OF FATHER (city or town) Va (State or country) Dinwiddie

12 MAIDEN NAME OF MOTHER Paulin White

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Father T T Eubank (Address)

15 Filed JUL 11 1922, 19.. J E Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922 to July 10, 1922

that I last saw h[illegible] alive on July 10, 1922

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Anterior Polio Myelitis

Infantile Paralysis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? observation

(Signed) Joseph E Sachse, M. D.

19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 11 1922

20 UNDERTAKER Wm Cook — ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65867 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 N. Rose ST., 6 WARD)

REGISTERED NO. 88

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Ulrich

(a) RESIDENCE NO. 406 N. Rose ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Frederick Ulrich

6 DATE OF BIRTH (month, day, and year): Sept 29-44

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frederick Ulrich

(Address): 406 N. Rose St

15 Filed JUL 11 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-7-yr, 19..., to July 9- 19 yr.

that I last saw her alive on July-9- 19 yr.

and that death occurred, on the date stated above, at 9 55 A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Arthritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. H. Herrmann, M. D.

7/-, 19 (Address) 2919 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: 7/12 1922

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Adams

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65868

CERTIFICATE OF DEATH.

REGISTERED NO. X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Boyd

(a) RESIDENCE. NO. 2021 Division ST. (Came from Philadelphia Pa WARD)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 weeks How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph Boyd.

6 DATE OF BIRTH (month, day, and year) 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic?

(b) General nature of industry, business, or establishment in which employed (or employer) Cleaning & Cooking

(c) Name of employer New York

9 BIRTHPLACE (city or town) (State or country) Hanover Co. Va.

PARENTS

10 NAME OF FATHER Benjamin Bowles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Co. Va.

12 MAIDEN NAME OF MOTHER Rosa Ann Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Co Va

14 Informant Mary A. Penn.
(Address) 2021 Division St

15 Filed JUL 11 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922 to July 9, 1922.

that I last saw h alive on July 9, 1922

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? N.Y. New York City

Did an operation precede death? No Date

Was there an autopsy? No

What test confirmed diagnosis? Physical Sensory

(Signed) Wm H Wright M. D.

, 19 (Address) Carey & Prestman Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn July	11 1922

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Before signing be careful to see that ALL ITEMS are properly supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65869

CERTIFICATE OF DEATH.

102 D 65869

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N. McCulloh ST., 14 WARD)

2-FULL NAME Mary Muirhead

(a) RESIDENCE NO. 512 N. McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. Prevention of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex Female 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years 53 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Richmond (State or country) Virginia

PARENTS

10 NAME OF FATHER Robt Muirhead

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Lowry

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant Fannie P. Bryatt

(Address) 512 N. McCulloh St.

15 Filed JUL 11 1922, 19 R. G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to July 9, 1922

that I last saw her alive on July 9, 1922

and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Pleurisy

over

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Carbuncle

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) R. Tarleton Schmidt, M. D.

July 11 1922 (Address) 1534 E. N. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Federal Hill DATE OF BURIAL July 11 1922

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
No pneumonia.
No further history.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65870

CERTIFICATE OF DEATH.

73 D 65870

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 W. Biddle ST., 11 WARD)

2-FULL NAME Sophia S. Redden

(a) RESIDENCE NO. 436 W Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Redden

6 DATE OF BIRTH (month, day, and year) — 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West River Maryland

PARENTS

10 NAME OF FATHER William Sargeant

11 BIRTHPLACE OF FATHER (city or town) (State or country) West River Maryland

12 MAIDEN NAME OF MOTHER Jane Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West River Maryland

14 Informant Charles A. Redden

(Address) 436 W. Biddle St

15 Filed JUL 11 1922, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 1922, to July 9th, 1922, that I last saw h— alive on July 7th, 1922, and that death occurred, on the date stated above, at 9 30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bulbar Paralysis (duration) 2 yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E. Mackenzie M.D. M. D.

July 11, 1922 (Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 12 1922

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65871 113 D 65871

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 Riggs Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn R. Stewart

(Residence in Baltimore: No. 1510 Riggs Ave St.; yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. October 10, 1920
(Month) (Day) (Year)

7-AGE. yrs. 9 mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Henry Stewart

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Hattie Dorsett

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Stewart

(Address) 1510 Riggs Ave.

15. Filed JUL 11 1922 192 C. S. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 10 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

Gastro-Enteritis (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia (Duration) yrs. mos. 2 ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

July 12 1922 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL. July 11 1922

20-UNDERTAKER. James H. Lewis ADDRESS 1303 Gay St

---

be properly classified. Exact statement of OCCUPATION

state CAUSE OF DEATH in plain terms, so that it may

is very important. See instructions on back of certificate.

D 65872 HEALTH DEPARTMENT---CITY OF BALTIMORE D 65872

CERTIFICATE OF DEATH

74-001

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Madison Av ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E. Lamb Brown

(Residence in Baltimore: No. 2001 Madison Av. St., ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): widowed

6-DATE OF BIRTH: July (Month) 24 (Day), 1842 (Year)

7-AGE: 79 yrs. 11 mos. 15 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Geo. M. Lamb

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Ann Woodward

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise B. Brown

(Address) 2001 Madison ave

15- Filed JUL 11 1922, 191 H. A. W. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 9, 1922, that I saw h... alive on July 9, 1922, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy, immediately fatal. (Duration) — yrs — mos — ds.

Contributory (SECONDARY) Arteriosclerosis

unknown (Duration) — yrs — mos — ds.

(Signed) Charles Lee Jr., M. D.

July 9th, 1922 [Address] 1111 N. Eutaw St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Green Mount DATE OF BURIAL: July 12, 1922

20-UNDERTAKER: John O. Mitchell ADDRESS: 120 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65873 65 — CERTIFICATE OF DEATH. — 131 D 65873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pascbell.

(a) RESIDENCE NO. 1303 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Paschell

6 DATE OF BIRTH (month, day, and year) Oct 14 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9.	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina (State or country)

PARENTS

10 NAME OF FATHER Thos. Paschell.

11 BIRTHPLACE OF FATHER (city or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Emeline Massey

13 BIRTHPLACE OF MOTHER (city or town) North Carolina (State or country)

14 Informant Fannie Paschall (Address) 1303 Division st

15 Filed JUL 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1922 to July 9 1922 that I last saw h alive on July 9 1922 and that death occurred, on the date stated above, at 10.10 P.m.

The CAUSE OF DEATH* was as follows:

Pyo Nephrosis

(duration) yrs. mos 21. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Surgical

(Signed) L. J. Gibson, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Bullock h. C.

DATE OF BURIAL 7-11 1922

20 UNDERTAKER George T. A. Gibson

ADDRESS 519 Fairmount Av

mation should be carefully supplied. AGE should be stated EXACTLY. Further information regarding CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65874 — 49 — D 65874

1-PLACE OF DEATH Hebrew Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Henry Eggers

(a) RESIDENCE. NO. 5314 Park Heights Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Aug 10 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Eggers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie F Eggers
(Address) 5314 Park Heights Ave

15 Filed JUL 11 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922 to July 9th, 1922 that I last saw h in alive on July 9th, 1922 and that death occurred, on the date stated above, at 11 50P m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/7/22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. Fuller Goodhart M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 12 1922

20 UNDERTAKER Isaiah Beyer ADDRESS 1600 W North ave

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 65875 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65875

CERTIFICATE OF DEATH.

REGISTERED NO. 131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. (St.) 4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Legambi

(a) RESIDENCE. No. 759 W. Saratoga St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Caroline Legambi Terranova

6 DATE OF BIRTH (month, day, and year): March 5, 1869

7 AGE — Years: 53 — Months: 4 — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fruit Importer

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Cefalu Italy

PARENTS

10 NAME OF FATHER: Vincenzo Petro Legambi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cefalu Italy

12 MAIDEN NAME OF MOTHER: Giovanna Castiglia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Polizza Italy

14 Informant (Address): James Legambi 759 W. Saratoga St

15 Filed JUL 11 1922 19 — W. A. Dell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 8, 1922, that I last saw him alive on July 8, 1922, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows: Myocardial insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pyonephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of Oct. 16, 1920

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis - P.S. & S.

(Signed) J. V. Scorbichi, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 7/12 1922

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65876

D 65876

CERTIFICATE OF DEATH.

33

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Frances Convent ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sister Mary de Chantell Gonzales.

(Residence in Baltimore: No. St. Frances Convent front & Chase St St.; 3 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, 4 (Month) 26 (Day), 1891 (Year)

7-AGE, 30 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Porto Rico

PARENTS.

10-NAME OF FATHER, Jesi Gonzales

11-BIRTHPLACE OF FATHER (State or Country), Porto Rico

12-MAIDEN NAME OF MOTHER Isabel Carero

13-BIRTHPLACE OF MOTHER (State or Country) Porto Rico

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother M. Thaddeus Asst.

(Address) St. Frances Convent

15-

Filed JUL 11 1922 GG

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1921, to July 1922, that I saw her alive on July 8 1922, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

.....

.....

Tuberculosis of Peritoneum.

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mary F. Donaleen M. D.

July 11., 1922 (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if out of place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, July 12., 1922

20-UNDERTAKER John B. Ryan

ADDRESS 1022 Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LANGUAGE OF OBSERVANT important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65877

49

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) Alameda Jnd. Gen. Hospx. ST.: 16 WARD)

2-FULL NAME Florida J. Ward

(a) RESIDENCE. NO. 739 N Fulton Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 3, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto-Co Md. Md

PARENTS

10 NAME OF FATHER Luther Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Self Chas. E. Ward 739 N. Fulton Ave

15 JUL 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9/22

17 I HEREBY CERTIFY, That I attended deceased from 6/20/22, 19 . to 7/9/22, 19 .

that I last saw her alive on 7/9/22, 19 .

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

1. Cardiac Insufficiency

CONTRIBUTORY (Secondary) Carcinoma Uterus (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1915

Was there an autopsy? —

What test confirmed diagnosis? Clynical Symp

(Signed) A. Tompkins, M. D.

, 19 (Address) Md Gen Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 12, 1922

20 UNDERTAKER George J. Smith

ADDRESS 5000 25 Fayette St

INFORMATION should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

REGISTERED No. D 65878

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
D 65878
CITY OF BALTIMORE (No. Sealey Sanatorium ST. 25 WARD)

2-FULL NAME Annie C. Davis.
(Residence in Baltimore: No. Sealey Sanatorium, Catonsville Md. St.: 30 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH May (Month) 15 (Day), 1840 (Year)

7-AGE 82 yrs. 1 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ood

9-BIRTHPLACE (State or country) Pa.

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Neal D. Currie
(Address) 1600 Park Ave

15. Filed JUL 11 1922 191 G G REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July (Month) 11 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1922, to July 11 1922, that I saw h[illegible] alive on July 10 1922, and that death occurred, on the date stated above, at 2a m.
The CAUSE OF DEATH* was as follows:

Senile Dementia.

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Arteio Sclerosis

(Duration) 10 yrs. mos. ds.

(Signed) Marshall B Hurst M.D.
July 11, 1922 (Address) Catonsville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 3 yrs. — mos. ds. In the State all life yrs. mos. ds.
Where was disease contracted, if not at place of death? /
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Wilmington Del
DATE OF BURIAL July 13, 1922

20-UNDERTAKER Wm Hickmotton
ADDRESS North & Fa

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65879

CERTIFICATE OF DEATH.

49 D 65879

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Driscoe

(a) RESIDENCE NO. 702 W. Lexington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 123

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Driscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Peggie Flannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JUL 11 1922 ROBERT N. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 10, 1922, that I last saw h im alive on July 10, 1922, and that death occurred, on the date stated above, at 8:10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of pancreas.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Mitchell M. D.

8/19/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem

DATE OF BURIAL July 11 1922

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St

Information should be carefully supplied. Note should be made if classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65880

D 65880

CERTIFICATE OF DEATH.

W-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3423 Leaverton Ave St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B Simmons

(Residence in Baltimore: No. 3423 Leaverton Ave St.; 65 yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 4 (Day), 1843 (Year)

7-AGE, 79 yrs. — mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Stephen A Simmons

(Address) 3423 Leaverton Ave

15- Filed JUL 17 1922, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 191..., to July 9 191..., that I saw h.. alive on July 9 191..., and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ...yrs. ...mos. 1 ...ds.

CONTRIBUTORY (Secondary) Cardiac Disease

(Duration) 5 yrs. ...mos. ...ds.

(Signed) P. H. Hermann M. D.

7 11 22, 191... (Address) 2919 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, July 13, 191...

20-UNDERTAKER Peter Nicolaus — ADDRESS Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65881 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 2 002 D 65881

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5617 Pratt ave. ST., 27 WARD)

2-FULL NAME Martha A. Francies

(a) RESIDENCE No. 5617 Pratt Ave. ST., Govans WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Francies

6 DATE OF BIRTH (month, day, and year): June 28th 1842

7 AGE: Years 80 | Months — | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: William G. Billington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co Maryland

12 MAIDEN NAME OF MOTHER: Ann Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co Maryland

14 Informant: Mrs E. L. Kountz

(Address) 5617 Pratt Ave. Balto.

15 Filed JUL 11 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1922

17 I HEREBY CERTIFY That I attended deceased from May 18th, 1922, to July 10th, 1922, that I last saw h alive on July 9th, 1922, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Decay

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. D. Mortemer, M. D.

19 (Address) 530 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waugh Cemetery

DATE OF BURIAL: July 12 1922

UNDERTAKER: Wade Lassahn

ADDRESS: Fullerton

mation should be carefully supplied. Age should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may

D 65882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 65882 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Milford Md. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Bernard Heinzerman

(Residence in Baltimore: No. 724 W. Gay st- St.; 18 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

6-DATE OF BIRTH. August (Month) 27 (Day) 1894 (Year)

7-AGE. 27 yrs. 10 mos. 13 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Joseph Heinzerman

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Barbara Maser-

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Heinzerman

(Address) 1232 Spring st Woodberry

15- FILED JUL 11 1922 ROBERT K. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 10 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken neck & wounds R. chest wall-

(Duration) ..... yrs. a few mins. mos. ..... ds.

CONTRIBUTORY (Secondary) fall from Ladder while at work.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Sommer M. D.
(Coroner.)

July 11 1922 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Catherdal — DATE OF BURIAL. July 15th 1922

20-UNDERTAKER. Wendel Rippelsden — ADDRESS 37 S. Conn

N. B.—Every item of information must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65883

CERTIFICATE OF DEATH.

89 D 65883

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 720 N. Carey ST., 16 WARD)

2-FULL NAME Mrs. E. Freslour.

(a) RESIDENCE NO. 720 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPA-

mation should be carefully supplied. Abbreviations should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry. Freslour

6 DATE OF BIRTH (month, day, and year) Jan. 8. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodsboro

(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Eichilberger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Clara Krebs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Miss Eichilberger

(Address) 723 N. Carey St.

15 Filed JUL 11 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17

I HEREBY CERTIFY, That I attended deceased from June 2 - 1922, to July 9 1922,

that I last saw her alive on July 5 1922,

and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Suddenly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2½ yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Bowman Stock, M. D.

7/9. 1922 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodsboro Md DATE OF BURIAL July 12 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1013 W. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56034 2nd copy

D 65884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58,001

D 65884

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Koeinicke

(a) RESIDENCE. NO. 1808 Ashburton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Sadie Koeinicke

6 DATE OF BIRTH (month, day, and year) Mar 31 - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Bernard Koeinicke

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Margaret Emerick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed ..... 19 JUL 11 1922 ROBERT F. KRAUSER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to July 10, 1922, that I last saw him alive on July 10 - , 1922, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Acute renal insufficiency

Uremia

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Pernicious anemia

(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. Stanley Burwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fredon Park Cemetery	July 13 1922
20 UNDERTAKER W M Routson	ADDRESS 2230 N Monroe

IMPORTANT—Fill in all items, if it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is very important. See instructions on back of certificates.

D 65885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65885

CERTIFICATE OF DEATH.

118-007

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Maloney Maloney

(Residence in Baltimore: No. 718 N. Howard St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 23, 1872
(Month) (Day) (Year)

7-AGE, 49 yrs. 8 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Horse
(b) General nature of industry, business, or establishment in which employed (or employer)..... Works

9-BIRTHPLACE. (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Jacob Connell

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Andrews

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Connell

(Address) 718 N. Howard

15-

Filed JUL 11 1922 ROBERT R. KRAUDER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10th, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ....
(Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus Causing
Intestinal Obstruction
Abt 8 Hrs (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY .....
(Secondary)
Nephritis (Duration) ...yrs. ...mos. ...ds.

(Signed) A. T. Ruby M. D.
(Coroner.)
July 10, 1922 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, July 12 1922

20-UNDERTAKER H. M. Routson

ADDRESS 2235 N Howard

N. B.—Every item of information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65886

CERTIFICATE OF DEATH.

113 D 65886

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 65886

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1207 Glyndon Ave ST., 21 WARD)

2-FULL NAME Naomi R Sparenberg

(a) RESIDENCE No 1207 Glyndon Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James V Sparenberg

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Hazel Geoghegan

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant J. V. Sparenberg
(Address) 1207 Glyndon Ave

15 JUL 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10/1922

17 I HEREBY CERTIFY, That I attended deceased from 7/10/22, 19 ..., to 7/10/22, 19 ..., that I last saw h alive on 7/10/22, 19 ..., and that death occurred, on the date stated above, at 1130 m. P

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Stephen Dean, M. D.

, 19 (Address) 1211 Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL July 12 19 22

20 UNDERTAKER James Dogwan & Son

ADDRESS 1011 S Pace St

READ carefully the following instructions. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Buchal V

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65887

CERTIFICATE OF DEATH.

178 D 65887

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1447 William ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace A Buchal

(a) RESIDENCE NO. 1447 William ST., 24 WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Herman Buchal

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Benedict Eyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Fleck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Geo Buchal 1447 William St.

15 Filed JUL 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 9, 1922, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Aortic Interpleted Regurgitation

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Herman Buchal M. D.

July 10 19 (Address) 1447 E. Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL July 12 19 22

20 UNDERTAKER J. J. Fahey & Sons

ADDRESS 1317 E. Biddle St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65888

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65888

CERTIFICATE OF DEATH.

160

REGISTERED NO.....

1-PLACE OF DEATH South Balt. Gen. Hospital.

CITY OF BALTIMORE: (No. 1213 Light ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Coralie Niemann.

(a) RESIDENCE NO. 724 Stockholm ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) Mar 24, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Niemann

11 BIRTHPLACE OF FATHER (city or town) Balt.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Adams.

13 BIRTHPLACE OF MOTHER (city or town) Balt.
(State or country)

14 Informant Frank Niemann
(Address) 724 Stockholm St

15 Filed JUL 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 10, 1922.

that I last saw h er alive on July 10, 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus a

Malnutrition.

(duration) ? yrs. ? mos ..... ds.

CONTRIBUTORY (Secondary) Dehydration.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Dalton M. D.

, 19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	July 13 1922
20 UNDERTAKER B. Lindenmeyer Son	ADDRESS 1029 Baltimore

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65889

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Scott St. ST., 21 WARD)

2-FULL NAME Charles Andrew Schwartz

(a) RESIDENCE NO. 1315 Scott St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 13" 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Schwartz

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Schwartz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Mary Schwartz
(Address) 1315 Scott St.

15 Filed JUL 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11" 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/10/22, 19..., to 7/11/22, 19..., that I last saw h[illegible] alive on 7/11/22, 19..., and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Stephen A Vann, M. D.

7/11 19 22 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL July 12 19 22

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N Balto St

information should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 65890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65890

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Franklin Square Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Shipferling

(a) RESIDENCE NO. 316 Spalding Ave. ST. Arlington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Frederick H. Shipferling

6 DATE OF BIRTH (month, day, and year) July 17" 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 937

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) Calvert Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Whittington

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Maryland

14 Informant Frederick H. Shipferling
(Address) 316 Spalding Ave. Arlington

15 Filed JUL 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10" 1922

17 I HEREBY CERTIFY, That I attended deceased from July 8 , 1922 , to July 10 , 1922 ,
that I last saw h alive on July 8 , 1922 ,
and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Confinement

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Abstraction

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? a a a h d

Did an operation precede death? Yes Date of 7/9/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/10 1922 (Address) 317 Forest St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL July 13 1922

20 UNDERTAKER Joseph L. Cook ADDRESS 1003 N Balto St

mation should be entirely supplied. Exact statement of OCCUPA-
be properly classified.
of certificates.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

(Ellenora Brown) v

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 65891

CERTIFICATE OF DEATH.

1019 D 65891

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 753 Dedmead ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellenora Brown

(a) RESIDENCE. NO. 753 Dedmead ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Private family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Martha Roberts

PARENTS

10 NAME OF FATHER Md

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: David Eaton (Address) 916 Dedmead

25 JUL 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to July 8, 1922, that I last saw her alive on July 8, 1922, and that death occurred, on the date stated above, at 840 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) A. K. Stevens M. D.

July 10, 1922 (Address) 712 Lemmon Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: July 12 1922

20 UNDERTAKER: David Eaton ADDRESS 916 Pac

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Calvert & 22.nd St. 12 - WARD)

REGISTERED No. C 188 - 003 D 65892

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie A. Harkins

(Residence in Baltimore: No. 1804 - E. Madison St. St.; yrs., 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col.	Married

6-DATE OF BIRTH, 3 (Month) 14 (Day), 1879 (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Prince George Co.

PARENTS.

10-NAME OF FATHER, Samuel H Berry

11-BIRTHPLACE OF FATHER (State or Country), Prince George Co

12-MAIDEN NAME OF MOTHER Ella Berry

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella Berry

(Address) 1804 E. Madison.

15-

Filed ..... 191.....

Registrar.

JUL 12 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries received from Automobile accident

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

1922 (Address) 2432 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Hod Lawn M. C.	July 12 1922
20-UNDERTAKER	ADDRESS
Mrs J. G. Locks	1302 Jefferson St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Where CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65893

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65893

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 122 Ropewalk La ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Spencer

(a) RESIDENCE. NO. 122 Ropewalk La ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (~~or WIFE of~~) Mary A Spencer

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	-	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman — 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Snow Hill Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Millie Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Spencer

(Address) 122 Ropewalk La

15 Filed JUL 12 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9/ 22

17 I HEREBY CERTIFY, That I attended deceased from July 2. 19 22. to July 9. 19 22.

that I last saw him alive on July 8. 19 22. and that death occurred, on the date stated above, at 3.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

yrs. mos. ds.

(duration) exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam,

(Signed) Harold E. Wagner M. D.

7/10. 1922 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cx

DATE OF BURIAL July 12 1922

20 UNDERTAKER L. L. Brown & Son

ADDRESS 1010 Monty

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be of certificates.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D 65894

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 W Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret D. Seigert

(a) RESIDENCE. (Usual place of abode) No. 746 W Lexington ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred about 35 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a ~~Married~~, widowed, ~~or divorced~~ (or) WIFE of Nathaniel Seigert

6 DATE OF BIRTH (month, day, and year) March 5 1839

7 AGE: Years 83; Months 4; Days 6; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Record at Augsburg Home (Address) 746 W Lexington St

15 Filed JUL 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1922, to July 11, 1922

that I last saw her alive on July 3, 1922

and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

old age

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) cardiac sclerosis

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W Newmeyer, M. D.

, 19 (Address) 700 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls. (Violetville) DATE OF BURIAL: 7-13 1922

20 UNDERTAKER: Mr Chas A G Rohde ADDRESS 600 N Arlington Ave

mation should be carefully supplied. ... be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65895

CERTIFICATE OF DEATH.

90 D 65895

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 237 S. Madeira ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Henry Cook

(a) RESIDENCE. NO. 237 S. Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER James R Cook

11 BIRTHPLACE OF FATHER (city or town) Balto - md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Fraser

13 BIRTHPLACE OF MOTHER (city or town) Balto md
(State or country)

14 Informant James R Cook
(Address) 237 S. Madeira

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922 to July 11, 1922
that I last saw h.... alive on July 11 6. a m 1922
and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis. Chronic
& Rheumatic Fever

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
Jan 12th 1922 (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M.D. Clyde Burns, M. D.

19 (Address) 22 & Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	July 12 1922
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Bank St

mation should be carefully supplied. Any unknown CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65896

D 65896

CERTIFICATE OF DEATH.

14-001

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 627 N. Collington Ave (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Stansbury

(a) RESIDENCE. No. 627 N Collington Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Edward Stansbury

6 DATE OF BIRTH (month, day, and year): Aug 4 1850

7 AGE — Years: 71 — Months: 11 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary E. Pohlman

(Address): 1430 E. Lanvale St.

15 Filed JUL 10 1922 19. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26 1922, to July 9 1922, that I last saw h.. alive on July 8 1922, and that death occurred, on the date stated above, at 7:05 P m.

The CAUSE OF DEATH* was as follows:

Cerebro-Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Coon M. D.

7/10 1922 (Address) 418 N Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 12 1922

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Eutaw St

mation should be carefully supplied. All blanks must be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65897

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 N. Poppelton ST., 18 WARD)

2-FULL NAME Paul Johnson

(a) RESIDENCE NO. 237 N Poppelton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bagest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Samuel Johnson

(Address) 237 N Poppelton St

15 Filed JUL 12 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922 to July 11, 1922

that I last saw him alive on July 11, 1922

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions + Cholera Infantum

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Dr. G. W. Kennard M. D.

7-11-1922 (Address) 708 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 12 1922

20 UNDERTAKER Brown & Sheeland

ADDRESS 114 N Schroeder St

mation should be entirely supplied. Also, should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65898

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65898

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE. NO. 931 N Collington ST.; 7 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Strzecka

(a) RESIDENCE. NO. 931 N. Collington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Strzecka

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Josef Petrila

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): John Strzecka 931 N Collington Ave

15 Filed JUL 12 1922, 19 W. A. Linn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 19, to July 10, 1922; that I last saw h alive on July 10, 1922; and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Green M. D.

19 (Address) 801 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 13 1922

20 UNDERTAKER: Emil Brachlow — ADDRESS: 1906 Eutaw

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65899 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65899

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 740 W. Hamburg ST. 21 WARD)

2-FULL NAME James. Keilholtz

(a) RESIDENCE (No. 740 W. Hamburg ST. WARD)
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan Keilholtz

6 DATE OF BIRTH (month, day, and year): August 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	76	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Keilholtz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Catherine Bernard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Henry Keilholtz 740 W. Hamburg

15 Filed JUL 12 1922 19 ..... H. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to July 10, 1922, that I last saw h alive on July 8, 1922, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Alt Ganghofner, M. D.

19 (Address) 517 Fremont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 13 1922

20 UNDERTAKER: Jos Joesdens. Son ADDRESS 217 S. Pen

mation should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65900 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65900

CERTIFICATE OF DEATH.

Registered No. C 25-182

1-PLACE OF DEATH

City of BALTIMORE: (No. 104 Olive St. Curtis Bay. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adela Mileski.

(Residence in Baltimore. No. 104 Olive St. Curtis Bay. St.; yrs. — 9 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female.	White.	Single.

6-DATE OF BIRTH. September 20th. 1921.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
----- yrs. 9 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS:

10-NAME OF FATHER. Ksawery Mileski.

11-BIRTHPLACE OF FATHER. (State or Country). Poland.

12-MAIDEN NAME OF MOTHER. Antonina Kalapeta.

13-BIRTHPLACE OF MOTHER. (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonina Mileski. (mother)

(Address) 104 Olive St. Curtis Bay.

15- Filed JUL 12 1922 192 H. Law Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 11th. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall into a wash boiler containing 5 inches of water.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)

July 12 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy C., ss 4. R.	July 12 1922

20-UNDERTAKER.	ADDRESS
John Grebliunas	915 S. Paca St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of conditions is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65901

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. 2047 Kaiser ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Jones

(a) RESIDENCE NO. 2047 Kaiser ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
16	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Peter Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Annie Jones

(Address) 2047 Kaiser St.

15 Filed JUL 12 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26 1922 to July 11, 1922

that I last saw her alive on July 11, 1922

and that death occurred, on the date stated above, at One P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Otis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) General Miliary T.B.

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? P.S. & S & autopsy

(Signed) J. A. Schenrich, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Drake Branch Charlotte Va	July 14 1922
20 UNDERTAKER Jno Robert A Elliott	ADDRESS 1725 Ashland Av

Information should be carefully supplied. AGE should be strictly correct. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65902 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65902

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1621 E. Madison ST.: 7 WARD)

2-FULL NAME Virginia Jones

(a) RESIDENCE. NO. 1621 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Jones

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C. N. C.

PARENTS

10 NAME OF FATHER Humphrey Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Annie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) Fred. B. Bond Waters 1621 E. Madison St

Filed JUL 12 1922 H. A. Mc. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 9, 1922, that I last saw her alive on July 9, 1922, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. O. C. Robinson M. D.

1922 (Address) 1522 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 12, 1922

20 UNDERTAKER Mrs Robt. A. Elliott ADDRESS 1725 Ashland Av

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 65903 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65903

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospitals ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Proutt

(a) RESIDENCE. No. Fairhaven Rd. ST., WARD. Fairhaven, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE~~ of Nettie Proutt

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self -

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Thomas -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Sunderland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Wife) Nettie Proutt
(Address) Fairhaven, Md.

15 Filed JUL 12 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 12, 1922, that I last saw him alive on July 12, 1922, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon (sigmoid flex.)

(duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Perforation and peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 10 + 11

Was there an autopsy? no -

What test confirmed diagnosis? Operation.

(Signed) L B Jones, M. D.
Assistant Visiting Surgeon

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cemetery

DATE OF BURIAL July 12 1922

20 UNDERTAKER B L Hopping

ADDRESS Annapolis Md

mation should be carefully supplied. AGE should be stated EXACTLY. If less than one year, state in days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65904 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65904

CERTIFICATE OF DEATH.

1567 54 Cw

1-PLACE OF DEATH

REGISTERED NO. 84

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude L. Wilde

(a) RESIDENCE. NO. Hazleton Pa. 230 N 1 ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~: Carrie K. Wilde

6 DATE OF BIRTH (month, day, and year): December 1871

7 AGE: Years 50 Months 8 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: William J. Wilde

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Saville Finney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 19 1922, 19 — A. Lane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to July 12, 1922, that I last saw him alive on July 12, 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor.
(Mycelium infection)

(duration) 0 yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 1.- June 25, 1922 2.- July 10, 1922

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation & laboratory findings

(Signed) Jay McKeen, M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hazleton Penna — DATE OF BURIAL: July 12 1922

20 UNDERTAKER: Wm. E. Blacke — ADDRESS: 927 N. Broadway

mation should be carefully applied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65905

D 65905

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 E. Eager ST., 4th WARD)

2-FULL NAME Christiana Tress

(a) RESIDENCE NO. 2012 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced (or) WIFE of: John F. Tress

6 DATE OF BIRTH (month, day, and year): Dec. 18, 1840

7 AGE — Years: 81 — Months: 6 — Days: 21 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Richard R. Knox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anastasia Powers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Maud Busch (Address) 2012 E. Eager st

15 Filed JUL 12 1922. 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-30, 1922 to 7-11, 1922 that I last saw h[illegible] alive on 7-18, 1922 and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Jordan P. M. D.

19 (Address) 1000 Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: July 14 1922

20 UNDERTAKER: Jenkins & Jenkins — ADDRESS 1739 Eager st

N. B.—WRITE PLAINLY, WITH PENCIL. AGE should be stated EXACTLY. Exact statement of DATE OF BIRTH should be carefully supplied. AGE should be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. CAUSE OF DEATH is very important. See Instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 65906 HEALTH DEPARTMENT—CITY OF BALTIMORE 65906

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Woodley St ST.. 16 WARD)

2-FULL NAME Margaret May Keimple

(a) RESIDENCE. NO. 1121 Woodley St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Keimple

6 DATE OF BIRTH (month, day, and year): June 5 1895

7 AGE: Years 27 Months ..... Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Daniel Mattison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Andrew Keimple 1121 Woodley St

15 Filed JUL 19 1922 . 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3. 19 to date of death that I last saw h[illegible] alive on July. 10, 19 22. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Emmy Lee Davis, M. D.

, 19 (Address) 824 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: July 13 19C

20 UNDERTAKER: Martin Fahey & Sons. — ADDRESS: 1827 W Pratt ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 65907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65907

CERTIFICATE OF DEATH.

187-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 655 W. Pratt St. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Irvin Lumbaum.

(Residence in Baltimore: No. 1428 Penna ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Sgle

6-DATE OF BIRTH. (Month) (Day) 1904 (Year)

7-AGE. 18 yrs. mos. ds. If LESS than 1 day, brs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. George Lumbaum

11-BIRTHPLACE OF FATHER, (State or Country) Balto Cnty

12-MAIDEN NAME OF MOTHER. Ida Ernsberger

13-BIRTHPLACE OF MOTHER, (State or Country) Balto Cnty

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Geo Lumbaum

(Address) 1428 Pennsylvania

15- Filed JUL 12 1922 192 H. Ahl Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 10 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy on~~ Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy on~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Head crushed in Elevator

(Duration) a few mins. hrs. mos. ds.

CONTRIBUTORY (Secondary) Accident in Elevator

(Duration) yrs. mos. ds.

(Signed) W B Gonnel M. D. (Coroner.)

7-12 1922 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer — DATE OF BURIAL. July 13 1922

20-UNDERTAKER. Martin Tuskey & Son — ADDRESS 1827 W North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65908 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65908

X 113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 707 S. Third St. (ST.,) (WARD) 26

2-FULL NAME Edna Viola Mach

(a) RESIDENCE NO. 707 S. Third St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Christopher Mach

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Edna Beil

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Christopher Mach
(Address) 707 S. Third St.

15 Filed JUL 12 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to July 10, 1922, that I last saw h[illegible] alive on July 10, 1922, and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus — Ovrt

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Carl Schneider, M. D.

7/11, 1922 (Address) 2439 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash Lawn Cem. DATE OF BURIAL July 14 1922

20 UNDERTAKER Lilly & Zeiler ADDRESS 4038 Wash Blvd

mation should be carefully supplied. AGE should be stated in years. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65909 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65909

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Wallis

(a) RESIDENCE. No. 2613 Greenmount ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Noreen Wallis

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Samuel F. Wallis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Daisy L. Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 12 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922, to July 11, 1922, that I last saw him alive on July 11, 1922, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Gallagher M. D.

7-11-22. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudoun	July 13 1922
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North Ave

mation should be carefully supplied. All blanks must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 65910

D 65910 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Orleans ST.: 5-th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tilarma A. Japark-

(a) RESIDENCE. NO. 1112 Orleans ST., 5-th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Japark-

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Howard Japark-

(Address) 1111 Orleans St

15 Filed JULY 2. 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1922, to July 11, 1922, that I last saw her alive on July 11, 1922, and that death occurred, on the date stated above, at 4-55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt. J. Green M. D.

7.11. 1922 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	7/14/ 1922
20 UNDERTAKER	ADDRESS
Wm Cook, 502 E.	North Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65911

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Jackson

(a) RESIDENCE. NO..... Port Deposit, Md. R.F.D. #2 ST..... WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Jackson

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Port Deposit Maryland

PARENTS

10 NAME OF FATHER Albert Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Randolph Jackson Port Deposit Md

15 JUL 12 1922 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1922, to July 11 1922, that I last saw him alive on July 11 1922, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Suppurative arthritis of elbow joint & left foot & leg

(duration) yrs. 1 mos. ? ds.

CONTRIBUTORY (Secondary) General Septicaemia

(duration) yrs. 1 mos. ? ds.

18 Where was disease contracted if not at place of death? Port Deposit, Md.

Did an operation precede death? Yes Date of July 3 - July 5

Was there an autopsy? not

What test confirmed diagnosis? Operation -

(Signed) Leon Freedom, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Port Deposit Md	July 12 1922
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exact cause of cellulitis not known. Deceased possibly scratched leg & caused infection. Streptococcus septicaemia

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65912 31 D 65912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 53 E Forest View Ave St., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria A Frank

(a) RESIDENCE NO. 53 E Forest View Ave ST. (Belmar) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 92 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 6 1829

7 AGE: Years 92 Months Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None WOD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Ernst Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosa Brenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Ernst Frank

(Address) 53 E Forest View Ave

15 Filed JUL 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 10, 1922, that I last saw her alive on July 10, 1922, and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

7/12 1922 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — DATE OF BURIAL: July 12 1922

20 UNDERTAKER: J Lucas — ADDRESS 2005 Alsop

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 65913

1-PLACE OF DEATH D 65913 REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Brown

(a) RESIDENCE No. 105 W. Hughes St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis, Md.

12 MAIDEN NAME OF MOTHER Eliza Molton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West River, Md.

14 Informant Hospital Records (Address) Municipal Hospital.

15 JUL 12 1922 ROBERT R. KRAUTER, Registrar

[redacted] Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 8, 1922, that I last saw her alive on July 8, 1922, and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/12/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65914

90

D 65914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Bell Ave ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily F. Vinson

(a) RESIDENCE NO. 1619 Bell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George L. Vinson

6 DATE OF BIRTH (month, day, and year) April 9th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	67	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co (State or country) Md

PARENTS

10 NAME OF FATHER James Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Richard Stewart (Address) 1612 Bell Ave

15 Filed JUL 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to July 10, 1922.

that I last saw her alive on July 10, 1922

and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease Heart

Do not Know (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. J. Carrick, M. D.

July 12 1922 (Address) 428 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crawfield Ind — DATE OF BURIAL July 13 1922

20 UNDERTAKER B. Schoonover & Son — ADDRESS Hanover Pa

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65915

CERTIFICATE OF DEATH.

49 D 65915

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Grantley Av ST., 15 WARD)

2-FULL NAME Albert Clinton Snow

(a) RESIDENCE NO. 2005 Grantley Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Clay Snow

6 DATE OF BIRTH (month, day, and year) May 17 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer) Board of Fire Underwriters

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Albert P. Snow

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Mollie Ogle

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Albert P Snow
(Address) 2005 Grantley Av

15 Filed JUL 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Cert.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922, to July 11, 1922,

that I last saw him alive on July 9, 1922

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Sarcomatosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chorio-epithelioma testicle

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of May 22

Was there an autopsy? No

What test confirmed diagnosis? Microscopic section

(Signed) Charles R. Nutman, M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	July 13 1922

20 UNDERTAKER Wm. B. Spencer & Son

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65916

74-001

D 65916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4801 Crowson Ave Evans ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. Barkman

(a) RESIDENCE. No. 4801 Crowson Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Geo W. Barkman (Otter Bausch)

6 DATE OF BIRTH (month, day, and year) Feb 5, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Barkman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Clara Otter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emmitsburg Md.

14 Informant (Address) Geo F. Barkman 4806 Crowson ave

15 Filed JUL 12 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1919 to July 7 1922, that I last saw h. alive on July 7 1922, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (Hemiplegia)

(duration) 1 yrs 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Cook, M. D.

July 14 1922 (Address) 1937 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 14 1922
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65917

16 082 65917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Robt. Garrett Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Kneff.

(a) RESIDENCE NO. 1618 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 31/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Kneff.

11 BIRTHPLACE OF FATHER (city or town) Balto Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Harvey

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Albert Kneff (Address) 1618 McHenry st.

15 Filed JUL 12 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 11, 1922, that I last saw her alive on July 11, 1922, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lawson Watkins, M. D.

July 11, 1922 (Address) 1014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL 7/13 1922

20 UNDERTAKER L. F. McCully — ADDRESS 430 E Fort

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma. Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bacillary

8

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65918 — CERTIFICATE OF DEATH. — X 440 D 65918

1-PLACE OF DEATH St. Agnes Hosp-

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mollie Keam.

(a) RESIDENCE NO. Freeland, Balto. Co. Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 Wks. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Wh.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Keam

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Va.

PARENTS

10 NAME OF FATHER Samuel Forrester.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Rock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) D. T. Forrester 1342 Harlem Ave

15 Filed JUL 13 1922, 19 ..... Registrar G.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13 19 22.

17 I HEREBY CERTIFY, That I attended deceased from 6/29, 19 22, to 7/13, 19 22.

that I last saw h.. alive on 7/13, 19 22.

and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Gall-bladder.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial failure Cardiac

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 14 19 22
20 UNDERTAKER	ADDRESS
Putnam & Gore	1125 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65919

CERTIFICATE OF DEATH.

45 D 65919

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2100 Maryland ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate A. Cosby.

(a) RESIDENCE. No. 2100 Maryland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: William H. Cosby.

6 DATE OF BIRTH (month, day, and year): 1843 - 9 - 1

7 AGE — Years: 78 — Months: 9 — Days: 18 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lady. f37
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellicott City Md.

PARENTS

10 NAME OF FATHER: Edwin Parsons Hayden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Hause

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ithula Va.

14 Informant: Mrs. Wm H. Cosby
(Address): 2100 Maryland ave.

15 Filed JUL 13 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 1917, 19—, to July, 1922, that I last saw her alive on July 10th, 1922, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

about (duration) 4 yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary): Emaciation

(duration) gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1917

Was there an autopsy? no

What test confirmed diagnosis? Obstructing growth at time of operation

(Signed) J. Kemp B. E. League, M. D.

19 (Address) 904 N. Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 7-13 1922

20 UNDERTAKER: Henry W. Jenkins Giaystons Co — ADDRESS: McCulloh & Orchard

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 6592 HEALTH DEPARTMENT—CITY OF BALTIMORE D 6592

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 W. Franklin ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Monroe Dennis

(a) RESIDENCE. No. 1827 W. Franklin ST., 20 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? 57 yrs. 3 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Virginia Dennis

6 DATE OF BIRTH (month, day, and year) March 15 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	57	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk at Appeal Tax Court.

(b) General nature of industry, business, or establishment in which employed (or employer) Appeal Tax Court of Balto.

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Emory Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary E. Belt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs Bessie S. Crokett (daughter)

(Address) 1827 W. Franklin St

15 JUL 13 1922 . 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10 . 19 22 . to July 12 . 19 22 .

that I last saw h alive on July 12 . 19 22 .

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [signature] M. D.

19 (Address) 5300 N. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL July 15 1922

20 UNDERTAKER STEWART & MOWER COMPANY

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65921 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65921

THE H
AN
ON TI
FORT.
O AS CAN
EXPENSE
TH IN SEC
LY HO
NK YO

CERTIFICATE OF DEATH.

90

OF DEATH

REGISTERED NO.

IMORE: (No. #21-East-22nd-Street. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

NAME Jesse Hopkins Plummer

NCE. NO. #21-East-22nd-St. ST., 12 WARD. (Resident)
sual place of abode) (If nonresident give city or town and State)

a city or town where death occurred 15 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 64 yrs. 11 mos. 23 ds.

ONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hammond Plummer

6 DATE OF BIRTH (month, day, and year) July-18-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Clerk to Sup't. of

(b) General nature of Industry, business, or establishment in which employed (or employer) P. R. R. at Union Sta.

(c) Name of employer Penna. R. R. Company.

9 BIRTHPLACE (city or town) Elkridge,
(State or country) Howard Co., Md.

PARENTS

10 NAME OF FATHER William W. Plummer

11 BIRTHPLACE OF FATHER (city or town) New Market,
(State or country) Frederick Co., Md.

12 MAIDEN NAME OF MOTHER Harriett French

13 BIRTHPLACE OF MOTHER (city or town) Phila.,
(State or country) Penna.

14 Informant Wm. M. Plummer, (son),
(Address) 3120-N-Calvert-St., City.

15 Filed JUL 13 1922, 19 H. Lamm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from 1 A.M. July 11, 1922, to 8.75 A.M., 1922,
that I last saw him alive on July 11, 1922,
and that death occurred, on the date stated above, at 8.75 A m.
The CAUSE OF DEATH* was as follows:

Heart failure with Pulmonary Edema. 7 1/2 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension
(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no special test

(Signed) Wm J Watson, M. D.

July 11 1922 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY	July-13-22

20 UNDERTAKER STEWART & MOWEN COMPANY
Wilbur F. WOOSER, Salesman

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hypertrophy of the Heart.

Spec.—1-10-21—M&T—1500 Bks.

D 65922 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65922

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 123 S. East Ave ST., 76 WARD)

2-FULL NAME Warren Edward Karow

(a) RESIDENCE NO. 123 S. East Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. T. Karow

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Rothe

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Wm. T. Karow
(Address) 123 S. East ave

15 JUL 13 1922 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1922

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1922, to July 11th, 1922, that I last saw him alive on July 11th, 1922, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY ✓
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam Jod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakdale Cemetery — DATE OF BURIAL July 14 1922

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 6592 3

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH American Sugar Refinery,

City of BALTIMORE: (No. Foot of Woodall St. St., 17 Ward)

Registered No. C 1822 D 6592 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Perry Jr. (C).

(Residence in Baltimore: No. 666 Bradley St. St.; yrs. ------ 4 ------ mos. ------ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. November 14th. 1895. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
26 yrs. 7 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER. George W. Perry (C).

11-BIRTHPLACE OF FATHER, (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Evangeline Talbert. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evangeline Perry (C) (mother).

(Address) 801 Barry Place. N.W. Washington D.C.

15-

Filed ..... 19.. ..... Registrar.

JUL 13 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 10th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a wharf.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) H. M. Barnhardt M. D. (Coroner.)

July 12, 192.. (Address) 1517 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Washington D.C.	July 13 1922

20-UNDERTAKER.	ADDRESS
John F. Denny	715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65924 HEALTH DEPARTMENT—CITY OF BALTIMORE 1 9 65924

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2140 E North Ave ST., 8 WARD)

2-FULL NAME John Kellner

(a) RESIDENCE NO. 2140 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mina Kellner

6 DATE OF BIRTH (month, day, and year) Dec. 18 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Kellner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Kellner Jr (Address) 2140 E North Ave

15 Filed JUL 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1922, to July 10, 1922,

that I last saw him alive on July 10, 1922,

and that death occurred, on the date stated above, at 11.05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of –

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

7/11, 1922 (Address) 1823 N. Mast St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL 7/13 1922

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PROFESSION or OCCUPATION should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 65925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65925

31

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 W. Fayette ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helena Merle.

(a) RESIDENCE. No. 935 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of George Merle

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Schenk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Louise Diem
(Address) 935 W. Fayette

15 Filed JUL 13 1922 19 H. Lane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to July 13, 1922, that I last saw her alive on July 13, 1922, and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

about 3 yrs. ~~mos.~~ ~~ds.~~
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Health Dept. Report.

(Signed) Frank N. Ogden, M. D.

19 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL July 15 1922

20 UNDERTAKER Geo. J. Smith

ADDRESS 1000 Fayette

BEING SURE TO BE CERTAIN. Supplies. Also should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65926

60-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. ..... ST.: 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Lawrence Conrad

(a) RESIDENCE. NO Arboville W Va ST., ... WARD. Arbokale, W. Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Lawrence Conrad.

6 DATE OF BIRTH (month, day, and year) October 26th, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Emory Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Eliza Woodall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Fred Conrad (Address) Arboville W Va

15 Filed JUL 13 1922 H. A. Mc Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1922.

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1922, to July 13th, 1922, that I last saw h[illegible] alive on July 13th, 1922, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Thyroid toxaemia and myocardial failure (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 12th, 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) Jno. T. Finney, M. D.

July 13, 1922 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arboville W Va	July 3 192[illegible]

20 UNDERTAKER William Cook ADDRESS 502 E Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65927

90 D 65927

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1414 (Moshier) ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Taylor

(a) RESIDENCE. NO. 1414 Moshier ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem'l	Col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas E Taylor

6 DATE OF BIRTH (month, day, and year) Nov 28-82

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer Harrisburg Pa

9 BIRTHPLACE (city or town) (State or country) Harrisburg Pa

PARENTS

10 NAME OF FATHER John Finley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emma Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Chas Taylor
(Address) 1414 Moshier

15 Filed ..., 19.. Registrar

JUL 13 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/22

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 12, 1922,

that I last saw h[illegible] alive on July 12, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm K Boyle, M. D.

7-12-22 (Address) 1418 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisburg Pa DATE OF BURIAL July 13 1922

20 UNDERTAKER Smith Brace & Son ADDRESS 1401 Moshier

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65928

161-001

D 65928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 Woodland Ave ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Storey

(a) RESIDENCE. NO. 223 Woodland Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				9½

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William Storey

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Mary Chilcoat

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Mrs Mary Storey
(Address) 223 Woodland Ave

15 Filed JUL 13 1922 ROBERT R. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11th 1922, to July 12th, 1922, that I last saw her alive on July 12th, 1922, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth (7 mos)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jennie R. Brown, M. D.

, 19 (Address) 5-10 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gessop Cemetery	July 13 1922
20 UNDERTAKER	ADDRESS
Wm C Brooks	Sparks Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65929 CERTIFICATE OF DEATH.

114 D 65929

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Armstrong

(a) RESIDENCE. NO..... ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July-4-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bay Shore, N.Y.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Bay Shore.
(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Hattie Jackson

13 BIRTHPLACE OF MOTHER (city or town) Bay Shore
(State or country) N.Y.

14 Informant P. S. Sweeney Warden
(Address) UNIVERSITY OF MARYLAND

15 Filed JUL 13 1922 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 9 1922

17 I HEREBY CERTIFY, That I attended deceased from May - 1 - 1922, to July - 9 - 1922, that I last saw him alive on July - 9 - 1922, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Gastro Enteritis

(duration) yrs. 3 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) William P. Schwark, M. D.

7/10, 1922 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL JUL 13 1922

20 UNDERTAKER Commissioner Health.
per. Wm. E. Woods.

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65930

CERTIFICATE OF DEATH.

31 D 65930

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tbc Hosp ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Harris

(a) RESIDENCE. No. 1204 W ~~4116~~ Fairmount Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of ~~—~~ Separated ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D. C.

PARENTS

10 NAME OF FATHER John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Virginia Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hosp. Records

15 Filed JUL 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 21 19 22, to July 9th 19 22, that I last saw h in alive on July 9th 19 22, and that death occurred, on the date stated above, at 1 15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) 7 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Sputum

(Signed) Francis L Daugherty M. D.

, 19 (Address) Municipal Tbc Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	JUL 1 1922
20 UNDERTAKER Commissioner Health, per Wm. E. WOODALL	ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. Particulars about CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65931

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1208 Glyndon ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Elizabeth Buffey

(a) RESIDENCE. NO. 1208 Glyndon ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 9/24/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bennett W. Buffey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Bennett W. Buffey

(Address) 1208 Glyndon

15 Filed JUL 13 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7 1922, to July 13, 1922

that I last saw her alive on July 12 1922

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D Hillis Hemming M. D.

7/13 1922 (Address) 7000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 14 1922
20 UNDERTAKER	ADDRESS
John J. Fiedler	1700 W. Lombard

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION of deceased is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

157044, D 65932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 65932

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Sturges.

(a) RESIDENCE. No. 331 Gwynn Ave. Balto. Md. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Betty Sturges (wife), Dumont N. Y.

6 DATE OF BIRTH (month, day, and year) June 6th, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles E. Sturges

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Ida Chambers,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa.

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed JUL 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1922, to July 13, 1922, that I last saw him alive on July 13, 1922, and that death occurred, on the date stated above, at 1-05 P.M. a.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) X yrs. 6 mos. X ds.

CONTRIBUTORY (Secondary) Operative Shock

(duration) X yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/12/22

Was there an autopsy? Partial

What test confirmed diagnosis? Microscopical.

(Signed) Jay Shelgren, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakeview Cem. New York via Dumont N.Y.

DATE OF BURIAL 7/13 1922

UNDERTAKER Chas. E. Love & Son

ADDRESS 1180 W. Royal Ave

NOTICE—Information should be carefully supplied. AGE should be stated in years and days. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Grace Walls) 65933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65933

CERTIFICATE OF DEATH.

D 65933

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST.: [illegible] WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Fair Walls

(a) RESIDENCE. No. Fairmont W. Va ST., WARD. Fairmont West Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Virgil L. Walls

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Joseph A. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Julia Bunner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Clyde A. Hill (Address) Fairmont W. Va

15 Filed JUL 14 1922 19 GG Registrar

Taken in late last night by Waterbury

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 30, 19 22, to July 13, 19 22, that I last saw her alive on July 13, 19 22, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Cholecystetis

Cholelithiasis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 3-22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Robert Hall M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W. Va

DATE OF BURIAL July 15 1922

20 UNDERTAKER Harry N. Witz 14 ADDRESS 153 W. Lombard St

---

mation should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 65934

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2338 Reisterstown Road 15 (WARD)

2-FULL NAME William J. Hayward

(a) RESIDENCE. No. 2338 Reisterstown Road WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All questions must be answered. Every statement must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Madeline E. Hayward

6 DATE OF BIRTH (month, day, and year) Mar 27, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10 NAME OF FATHER Wm B. Hayward

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mary Talbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant Madeline E. Hayward
(Address) 2338 Reisterstown Road

15 Filed JUL 14 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12-1922

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to July 12, 1922, that I last saw h~~im~~ alive on July 11, 1922, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.
(Chronic Interstitial nephritis)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation & Dilatation Heart (duration) 25 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S. Aschenbrenner, M. D.

7-13, 1922 (Address) 4012 Pard Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	July 14 1922

20 UNDERTAKER ADDRESS

John O. Mitchell & Son Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65935

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 D 65935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.: 21 WARD)

2-FULL NAME ~~Fred~~ Vernon Brown

(a) RESIDENCE. NO. 1445 Wood St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Child.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) 7/12 [redacted]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	2	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 200

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ernie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) David Eccles 2210 Fe

15 Filed JUL 14 1922 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/12, 1922, to 7/12, 1922, that I last saw him alive on 7/12, 1922, and that death occurred, on the date stated above, at 4.35 p. m.

The CAUSE OF DEATH* was as follows:

Uremic Bronchopneumonia

(duration) - yrs. - mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? above address

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical Evidence.

(Signed) [signature] M. D.

, 19 (Address) 604 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 14 1922
20 UNDERTAKER David Eccles	ADDRESS 2210 Fe

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65936 D 65936

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4801 Fifth Ave. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Manning.

(a) RESIDENCE NO. 4801 Fifth Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 21-1921.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Manning.

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Hilt

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Michael Manning.
(Address) 4801 Fifth Ave.

15 Filed JUL 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 12, 1922, that I last saw h.. alive on July 12, 1922, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Glantz, M. D.

, 19 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL July 14 1922

20 UNDERTAKER Tilly & Zeiler ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65937 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65937

CERTIFICATE OF DEATH.

16-002

1-PLACE OF DEATH Garrett Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 27 N. Carey Street ST., 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Klerlein

(a) RESIDENCE NO. 765 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Klerlein

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Stella Byrnes

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Stella Klerlein
(Address) 765 W. Lexington St

15 Filed JUL 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1922, to July 12, 1922, that I last saw h[illegible] alive on July 12, 1922, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Dysentery 000

2 wks.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pemphigus 2 days

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Nursery & Child's

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Charles Cramer, M. D.

7/13, 1922 (Address) 700 N Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL July 14 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. Prescribing CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bacillary.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 65938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65938

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1629 St Paul (St.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma R. Lassabee

(a) RESIDENCE. (No) 1629 St Paul ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(h) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: E. T. Lassabee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: E. T. Lassabee

(Address) 4008 Resideron Road

Filed JUL 14 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20th, 1920, to July 12th, 1922, that I last saw her alive on July 12th, 1922, and that death occurred, on the date stated above, at 7- P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. L. Shearer, M. D.

July 13, 1922 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 14 1922
20 UNDERTAKER	**ADDRESS**
Harry Perkins Sons Co	Greenmount Ave

THIS IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65939

D 65939

CERTIFICATE OF DEATH.

46

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2038 Bank ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Szymanowski

(a) RESIDENCE NO. 2038 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Frank Szymanowski Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 47 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Frank Krisgist

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Cacbeni —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Frank Moecl (Address) 2038 Bank St

15 Filed JUL 14 1922, 19 ..... Registrar H. A. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922 to July 12, 1922

that I last saw h[illegible] alive on July 12, 1922 and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) Yrs. 16 mos ds.

CONTRIBUTORY (Secondary) Cardio-Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 21, 21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J. Power, M. D.

July 13 22 (Address) 8016 Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem.

DATE OF BURIAL: July 15 1922

20 UNDERTAKER: Jacob Fiallowski ADDRESS 427 S. Bond Street

N. B.—WRITE PLAINLY, with ink only. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65940 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65940

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1546 W Lanvale ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Heinzenberger

(a) RESIDENCE. NO. 1545 W Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of nee Wieland Bertie Heinzenberger

6 DATE OF BIRTH (month, day, and year) Dec 29 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home for 1 year. 045

(b) General nature of Industry, business, or establishment in which employed (or employer) Paint Dealer.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Conrad Heinzenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Oswold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Bertie Heinzenberger (Address) 1546 W Lanvale St.

15 Filed JUL 14 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/22 19

17 I HEREBY CERTIFY, That I attended deceased from Feb., 1921, to July 12, 1922, that I last saw him alive on July 11th, 1922, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
1 5 John Wolff M.D.
(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Changed aug 9/1922
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical & microscopical

(Signed) John Wolff, M. D.

, 19 (Address) 1543 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 15 22

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65941

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1165 Carey St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry H Gilbert.

(a) RESIDENCE. NO. 116 S Carey St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 2-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7 8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry H Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sophia Simons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Father Geo H. Gilbert

(Address) 116 S. Carey St

Filed JUL 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/22

17 I HEREBY CERTIFY, That I attended deceased from 7/10/22, 19..., to 7/12/22, 19..., that I last saw h... alive on 7/12/22, 19..., and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hard Colitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T H Bennett, M. D.

7/13/22 (Address) 1302 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 14 1922

20 UNDERTAKER: Harry H Witzke — ADDRESS: 153 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65942

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1034 Ensor ST., 10 WARD)

2-FULL NAME Augusta Biles

(a) RESIDENCE NO. 1034 Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Joseph S. Biles

6 DATE OF BIRTH (month, day, and year) May 14 Th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Oberlander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Galster (Address) 1034 Ensor

15 Filed JUL 14 1922 H. A. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to July 12, 1922, that I last saw her alive on July 12, 1922, and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. L. Hornstein, M. D.

7/13, 1922 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL July 15th 1922

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65943

CERTIFICATE OF DEATH.

REGISTERED NO. C 118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 W. Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Pitts

(Residence in Baltimore: No. 235 W. Preston St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, May 27, 1870 (Month) (Day) (Year)

7-AGE, 52 yrs. 1 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 071
(b) General nature of industry, business, or establishment in which employed (or employer) Cook

9-BIRTHPLACE, (State or Country), Hartford Co Md

PARENTS.

10-NAME OF FATHER, Joseph H. Pitts

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriet Hanbury

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Pitts

(Address) 235 W. Preston

15- Filed JUL 14 1922, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 191, to July 12 1922, that I saw h alive on 191, and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 3 Days

CONTRIBUTORY (Secondary) Cardiac Dynamic

(Duration) yrs. mos. 4 Yrs

(Signed) H. Grantham M. D.

July 12, 1922 (Address) 1354 N. Bolton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hartford Co Md

DATE OF BURIAL, 7-15-22

20-UNDERTAKER George H. Holland

ADDRESS 1631 Eutaw

Hilton

N. B.—Every item of information called for in this CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

ANNA ZIGNOWSKA.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65944

D 65944

58-001

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 S. Bethel ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Zignowska

(Residence in Baltimore: No. 708 S. Bethel St.; 48 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Don't Know, ... (Month) ..... (Day) 1 ..... (Year)

7-AGE, 79 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, — Borkowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... M. J. Sadowski .....

(Address)..... 705 S. Ann St .....

15- JUL 14 1922, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1922, to July 6 1922, that I saw h[illegible] alive on July 6 1922, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

..... Pernicious Anemia .....

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. J. Sundaufer M. D.

13-7-, 1922 (Address) 732 S. Ann

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, H. Harmans, Md. DATE OF BURIAL, July 15, 1922

20-UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann St

N. B.—Every item of information must be carefully classified. Exact statement of OCCUPATION very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 65945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65945

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3316 Fleet ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Affayroux

(a) RESIDENCE NO. 3316 Fleet St. ST., 2E WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 6th 1884

7 AGE: Years 38 Months 7 Days — If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman at Bethl.

(b) General nature of industry, business, or establishment in which employed (or employer): Steel Co. O&V

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James Affayroux

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary Hatem

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Frank J. Affayroux

(Address): 1038 Madison Ave

Filed JUL 14 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12th 1922

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1922, to Jul ..., 1922, that I last saw him alive on July 5, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

1 Tuberculosis Pulmonis

(duration) 1 yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) General asthenia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benj. Kader M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: July 15 1922

20 UNDERTAKER: Lilly & Julian — ADDRESS: 4008 Wash Blvd

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65946

D 65946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1361 Whatcoat ST.: 15 WARD)

2-FULL NAME Maria Brown

(a) RESIDENCE. No. 1361 Whatcoat ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

3a If married, widowed or divorced HUSBAND of (or) WIFE of Washington Brown not known.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Missionary 1165

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Sandy Brown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant James Deems
(Address) 1213 Druid Hill Ave.

15 Filed JUL 14 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11— 1922, to July 12 1922, that I last saw h[illegible] alive on July 12 1922, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Renal Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcellus E. Stone, M. D.

, 19 (Address) 1479 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	July 15 1922
20 UNDERTAKER James H. Deems	ADDRESS 1303

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

D 65947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65947

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1817 Jackson St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Fulton.

(Residence in Baltimore: No. 1817 Jackson St. St.; 19 yrs., 4 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. March 3rd. 1903. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
19 yrs. 4 mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Andrew Fulton.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Nettie Stewart.

13-BIRTHPLACE OF MOTHER, (State or Country). Talbot Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Fulton. (mother)

(Address) 1817 Jackson St.

15- Filed JUL 14 1922 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nebhritis.
Gonorrhea.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

July 13th 1922 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	July 15 1922
20-UNDERTAKER.	ADDRESS
Wm Cook	[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65948

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2548 Eager Place Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Messner

(Residence in Baltimore: No. 2548 Eager Pl. St.; yrs., 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	W	Widowed

6-DATE OF BIRTH Sept. 21, 1847
(Month) (Day) (Year)

7-AGE. 74 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Barbara Holtkamp

(Address) 2548 Eager Pl.

15- Filed JUL 14 1922 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hem. Phlegm

(Duration) ..1.. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Paul M. D.
(Coroner.)

7-12 192x (Address) 508 E. North ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, July 15, 19..22

20-UNDERTAKER, Wm Cook, ADDRESS 502 E. North ave

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 65949 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65949

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5211 St. Charles Ave. WARD 27)

2-FULL NAME Margaret E. Ballard

(a) RESIDENCE No. 5211 St. Charles Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Victor J. Harry S. Ballard

6 DATE OF BIRTH (month, day, and year): Feby 14 1870

7 AGE: Years 52 Months 4 Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles C. Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Dyer Huber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry S. Ballard Jr.

(Address) 5211 St. Charles Ave

15 Filed July 12 1922 E. A. Abbe Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1922, to July 11, 1922, that I last saw h[er] alive on July 11, 1922, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Melancholia

(duration) — yrs. 2 mos 5 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & cancer

(Signed) Chas. J. Hill, M. D.

, 19 (Address) Wyler ave. city

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL July 14 1922

20 UNDERTAKER: Williams Bal 5028 Northern ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and also State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Charles Hill Wyler ave Assistant

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65950

148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1243 William ST.: 2 WARD)

2-FULL NAME Bertilla Price

(a) RESIDENCE. No. 1243 William St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Price

6 DATE OF BIRTH (month, day, and year) June 21, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles J. Sichelstiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Kunze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs C. J. Sichelstiel

(Address) 1243 William St.

Filed JUL 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17

I HEREBY CERTIFY, That I attended deceased from July 5 1922 to July 12 1922

that I last saw her alive on July 12 1922

and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Acute nephritis of pregnancy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Post partum Eclampsia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. E. Stiger, M. D.

7/12 1922 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	7/15 1922
20 UNDERTAKER	ADDRESS
Jos L Baker & Sons	1318 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65951

33

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 538 N Carrollton Ave ST., (WARD)

2-FULL NAME Laura V Brewer

(a) RESIDENCE NO. 538 N Carrollton Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of S. H. B. Brewer

6 DATE OF BIRTH (month, day, and year) April 8, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Hagerstown Md
(State or country)

PARENTS

10 NAME OF FATHER Jacob Mossner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Lorich

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Clark Hardesty
(Address) 538 N Carrollton Ave

Filed JUL 14 1922, 19 W. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/ 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 13, 1922, that I last saw h[illegible] alive on July 13, 1922, and that death occurred, on the date stated above, at 1:10 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

(duration) yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary) Mal Nutrition (duration) yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Stephen Strain, M. D.

July 14 1922 (Address) 1122 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL Hagerstown Md — DATE OF BURIAL JUL 14 1922, 19

20 UNDERTAKER Geo W Little — ADDRESS 2706 Edmondson Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 65952 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65952

CERTIFICATE OF DEATH.

58-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2315 E. Monument ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia V. Voght

(a) RESIDENCE NO. 2315 E Monument WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of John C Voght

6 DATE OF BIRTH (month, day, and year) Sept 19 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	9	24	

8 OCCUPATION OF DECEASED — 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Joyner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia A. Buyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John C Voght Jr 2315 E Monument St

Filed JUL 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 22

17 I HEREBY CERTIFY, That I attended deceased from July 2 1921, to July 13 1922

that I last saw him alive on July 13 1922

and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo. Edwin Brady M. D.

, 19 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL July 15 1922

20 UNDERTAKER McGinnis-Worrell

ADDRESS 4203 Ridgewood Ave

Be sure that every question is answered. Information should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate it. OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65953

CERTIFICATE OF DEATH.

32

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME August J. Edward Staff

(a) RESIDENCE. No. 3116 Stafford St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of SUPPLEMENTARY INFORMATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1. 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER August J. Staff

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Clara Smelser

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

11 Informant Hosp Records
(Address)

15 Filed JUL 14 1922 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17

I HEREBY CERTIFY, That I attended deceased from July 9. 1922 to July 12. 1922

that I last saw h[illegible] alive on July 12 1922

and that death occurred, on the date stated above, at 6 35 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 25 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 1922

Was there an autopsy? no

What test confirmed diagnosis? Exam. of spinal fluid

(Signed) W. B. Jones. M. D.

7/12 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 15 1922
20 UNDERTAKER	ADDRESS
Mr. & Mrs John W. Teufel & Son	801 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

MD 65954

HEALTH DEPARTMENT—CITY OF BALTIMORE

MD 65954

161-09

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 Longwood ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellis Feller

(Residence in Baltimore: No. 2009 Longwood St.; ..... yrs. ..... mos. 7 hrs. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, July (Month) 13 (Day), 1922 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Child .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Antony Feller

11-BIRTHPLACE OF FATHER (State or Country), Hungaria

12-MAIDEN NAME OF MOTHER Julia Kochlick

13-BIRTHPLACE OF MOTHER (State or Country), Hungaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anton Feller

(Address) 2009 Longwood St

15-

Filed JUL 14 1922 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 13 (Day), 1922 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 13 1922, to July 13 1922, that I saw her alive on July 13 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Paralysis of Spinal Cord

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Difficult delivery

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. S. L. Williams M. D.

July 14, 1922 (Address) 1310 N Broadway

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, Sunday 16 1922

20-UNDERTAKER Wm Fleckenstein & Son

ADDRESS N Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D 65955

HEALTH DEPARTMENT—CITY OF BALTIMORE D 65955

CERTIFICATE OF DEATH.

REGISTERED NO. X 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm James Merrick

(a) RESIDENCE. No. 1560 Fremby Ave. Columbus, Ohio. (Ward.)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced (HUSBAND of or WIFE of): Mr. James F. Merrick (Son)

6 DATE OF BIRTH (month, day, and year): April 17 1922

7 AGE: Years 62 Months 2 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Passenger Conductor R.R.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: John Merrick.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Ellen Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: JOHNS HOPKINS HOSPITAL Records.

(Address)

Filed JUL 14 1922, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to July 13, 1922, that I last saw him alive on July 13, 1922, at 2.30 P. m., and that death occurred, on the date stated above, at 2.30 P. m.,

The CAUSE OF DEATH* was as follows:

(1) Malignant Papillomatous bladder.

(2) Pyelonephritis

(3) Perinephritic Abscess (right)

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): (1) Leukemia (2) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. W. Finnigan, M. D.

7-13 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbus Ohio — DATE OF BURIAL: July 14 1922

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back may be of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 65956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65956

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 E. Preston ST.; 8 WARD)

2-FULL NAME John R. Ruckert

(a) RESIDENCE. NO. 2601 E. Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Sarah Ruckert

6 DATE OF BIRTH (month, day, and year) May 16 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis Ruckert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs. Sarah Ruckert (Address) 2106 E. Preston st.

Filed JUL 14 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1922, to July 12, 1922, that I last saw him alive on July 12, 1922, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green M. D.

7-14. 1922 (Address) 120 Aisquith st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	7-15 1922
20 UNDERTAKER	ADDRESS
William Cook.	602 E. North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 65957 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65957

CERTIFICATE OF DEATH. K 46

1-PLACE OF DEATH Woman's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 14 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Schmid Reitz

(a) RESIDENCE NO. Meadowbrook Ave. Catonsville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f.	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Mike Reitz

6 DATE OF BIRTH (month, day, and year) April 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	58	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Miss Ida Reitz (Address) Catonsville

15 Filed JUL 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to July 13, 1922, that I last saw h[illegible] alive on July 13, 1922, and that death occurred, on the date stated above, at 6 00 a m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Ovary

(duration) 9? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 27,

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A. H. Duncan, M. D.

7/13, 1922 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem Lutheran Cem DATE OF BURIAL July 15, 1922

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65958

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3537 Bunson ST. 13 WARD)

2-FULL NAME Jno Morton Bridgett

(a) RESIDENCE. (Usual place of abode) No. 3537 Benson ST., 13 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Thos J. Wright

11 BIRTHPLACE OF FATHER (city or town) Balti
(State or country) Md

12 MAIDEN NAME OF MOTHER Estelle Snell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Thos J. Wright
(Address) 3537 Benson or

15 Filed JUL 14 1922 19 W. Adams Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1922, to July 14, 1922, that I last saw him alive on July 13, 1922, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Hyaline Membranes -
Premature child 7th month

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY
(Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Examination

(Signed) R B Norment, M. D.

7.14. 1922 Address 3645 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: July 14 1922

20 UNDERTAKER W S Udenhall — ADDRESS 3539 Falls Rd

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65959

CERTIFICATE OF DEATH.

18-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. Mercy Hospital 15 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Gordon

(Residence in Baltimore: No. 2403 Elsinor Ave St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Widower

6-DATE OF BIRTH: June (Month) 21 (Day) 1839 (Year)

7-AGE: 83 yrs. — mos. 21 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: lumber inspector
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: George W. Gordon

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Jane Eglestone

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Nannie L. Coy

(Address) 2403 Elsinor Ave

15- Filed JUL 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 12 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull,
R. Car Accident

(Duration) ..... yrs. ..... mos. 2 hrs.

CONTRIBUTORY (Secondary) Concussion of Brain

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Webb M. D.

July 12 1922 (Coroner's Address) 4317 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cathedral	July 15 1922

20-UNDERTAKER: John A. Mitchell ADDRESS 1701 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Any illegible or incomplete statement will delay the record being properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65960

D 65960

CERTIFICATE OF DEATH.

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 528 N-Mount ST., (or) 19 WARD)

2-FULL NAME Jno B. Hill

(a) RESIDENCE NO. 528 N-Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widower ~~Jno B. Hill~~

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of ~~Mamie Hill~~

6 DATE OF BIRTH (month, day, and year) April 12, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier 086

(b) General nature of industry, business, or establishment in which employed (or employer) U S Army Retired

(c) Name of employer U S Army

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER Rachel [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant (Rachel Hill) (Address) 528 N-Mount St

15 Filed JUL 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1922, to July 12, 1922, that I last saw h[illegible] alive on July 12, 1922, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Walter Dickens, M. D.

, 19 (Address) 1818 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cmtry — DATE OF BURIAL July 16 1922

20 UNDERTAKER J Leon Hall — ADDRESS 1741 D Ave

N. B.—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65961 .38

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 235 So. Spring St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Charles Jackson

(Residence in Baltimore: No. 235 So. Spring St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Unknown ..... (Month) ..... (Day) ..... (Year)

7-AGE. About 6x yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 048

9-BIRTHPLACE. (State or Country). Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Brown

(Address) 235 So. Spring St

15- Filed JUL 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit CR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, and ..... find that said deceased came to death (Autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Failure

Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

July 8 1922 (Address) Curtis Bay, Md

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, July 1922

20-UNDERTAKER. Wm. [illegible] ADDRESS

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65962

CERTIFICATE OF DEATH.

31 D 65962

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hospital ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugenio Otters

(Residence in Baltimore: No. 1 Thames & Bond St St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

6-DATE OF BIRTH. Unknown ..... 1.....
(Month) (Day) (Year)

7-AGE. About 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

186

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Police Sta

15- JUL 14 1922
Filed Morgue 192.....
ROBERT N. KRAUTER
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12th 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Lungs
Tuberculosis
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(Duration) ..... mos. ..... ds.

(Signed) Thos. B. Morton M. D.
(Coroner.)

July 13 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, JUL 14 1922

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND
Health,

Spec.—1-10-21—M&T—1500 Bks.

D 65963

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 65963

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 227 Dolphin ST., 11 WARD)

2-FULL NAME Maggie Jackson

(a) RESIDENCE NO. 227 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Williams Jackson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andy Broughton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Honey Linthicum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Broughton

(Address) 1711 Lombard St

15 Filed JUL 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27th 1922 to July 13 1922

that I last saw h alive on July 13th 1922

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows: (

Acute dilatation of the heart

(duration) Some minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic heart disease

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? 704 Argyle Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Jos. Ellis M. D.

1922 (Address) 72 Somerset Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Williamsport Md DATE OF BURIAL July 15 1922

20 UNDERTAKER John A Owens ADDRESS 5-38 Dolphin St

N. B.—WRITE PLAINLY, with indelible pencil. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65964

CERTIFICATE OF DEATH.

90 D 65964

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 Eastern Ave St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludwig Richter

(Residence in Baltimore: No. 2010 Eastern Ave St.; 66 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Nov 19, 1838 (Month) (Day) (Year)

7-AGE, 83 yrs. 8 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cobbler
(b) General nature of industry, business, or establishment in which employed (or employer): 088

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Minnie Richter

(Address) 2010 Eastern Ave

15- Filed JUL 14 1922 ROBERT R. KRAUTER, Clerk ... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13th 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1922, to July 13 1922, that I saw h[illegible] alive on July 11 1922, and that death occurred, on the date stated above, at 1045 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. ... mos. ... ds.

(Signed) J. J. McAvoy M. D.

July 14, 1922 (Address) 833 S. Edwards

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, I. O. German — DATE OF BURIAL, July 17, 1922

20-UNDERTAKER Peter Nicolaus — ADDRESS Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 65965

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 65965

CERTIFICATE OF DEATH.

113

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Schneiders Court ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Buttner

(Residence in Baltimore: No. 1722 Schneiders Court St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, October (Month) 9 (Day), 1921 (Year)

7-AGE, ...yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wiktor Buttner

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Teofila Wagierka

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wiktor Buttner

(Address) 1722 Schneiders Court

15- JUL 15 1922 filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1922, to July 11 1922, that I saw h.im alive on July 11 1922, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Marasmus

1 month

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Jaundice

(Duration) ....yrs. ....mos. 24 ds.

(Signed) L. C. Swanda M. D.

7-14-, 1922 (Address) 722 S. Ann

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, July 17, 1922

20-UNDERTAKER Stephen F. Fialkowski ADDRESS 1037 Kenwood Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very careful to have CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 65966 D 65966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 875 Lennon St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Graf

(Residence in Baltimore: No. 875 Lennon St. St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Dont Know. 1864
(Month) (Day) (Year)

7-AGE. 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. August Hoffman

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Eva Kalpusmus

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Hoffman

(Address) 875 Lennon St

15- Filed JUL 15 1922 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 14 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ or Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au~~ ..... ~~topsy or Inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H K Gonce M. D.
(Coroner.)

7-15 1922 (Address) 117 W Saratoga St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem DATE OF BURIAL. July 17 1922

20-UNDERTAKER. John J Cowan Son ADDRESS 901 Hollins St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 65967

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Guilford Ave & 21st St.

CITY OF BALTIMORE: (No. Home for Incurables ST.: 12 WARD) 40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Buckler Innis

(a) RESIDENCE. NO. Home for Incurables. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) about ? — ? — 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 068

(b) General nature of industry, business, or establishment in which employed (or employer) School teacher

(c) Name of employer

9 BIRTHPLACE (city or town) unknown (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) unknown

14 Informant Dr. Fannie Hooper.

(Address) 1307 N. Charles St

15 Filed JUL 15 1922 19 T. A. Wood Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12 1922, to July 14 1922, that I last saw her alive on July 13 1922, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & signs

(Signed) J. A. Chatard, M. D.

July 15 1922 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 15 1922
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65968

CERTIFICATE OF DEATH.

90 D 65968

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4315 Phila. Ave ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Holston

(a) RESIDENCE NO. 4315 Phila ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Nellie Holston

6 DATE OF BIRTH (month, day, and year): Feb 5-76

7 AGE — Years: 46 | Months: 5 | Days: 8 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Near Beer

(b) General nature of industry, business, or establishment in which employed (or employer): Saloon 044

(c) Name of employer: Keeper

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Jos. Holston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Nellie Holston

(Address): 4315 Phila ave

15 Filed JUL 15 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/13 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/10/22, 19..... to 7/13/22, 19.....

that I last saw him alive on 7/13/22, 19.....

and that death occurred, on the date stated above, at 11-15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Bronchitis

(duration) yrs. 1 mos 19 ds.

CONTRIBUTORY (Secondary): Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Garnell M. D.

7/16 1922 (Address) 633-S-3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 7/17 1922

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 65969 HEALTH DEPARTMENT—CITY OF BALTIMORE D 65969

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W Cross ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Bucker

(a) RESIDENCE. No. 702 W Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henrietta J Bucker

6 DATE OF BIRTH (month, day, and year) Dec 28 - 81

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Natural Stamping

(c) Name of employer Enamel Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER G Lewis Bucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth [illegible] 7/12. 1922

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant J Walter Bucker
(Address) 2319 E Eutaw

15 Filed JUL 15 1922 19 T H A Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12. 1922

17 I HEREBY CERTIFY, That I attended deceased from August 1 1921, to July 12 1922, that I last saw him alive on July 12 1922, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G E Buxton, M. D.

7/12. 1922 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	7/15 1922
20 UNDERTAKER Philip Herring	ADDRESS 2016 Aliceanna

X. B.—WRITE LEGIBLY, with pencil or ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 65970

Spec. 6-[illegible] 1000 Bks.

D 65970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Braun

(a) RESIDENCE. NO. 3136 Stafford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single (Baby)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) apl 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank J. Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Bertha McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mother - Bertha Braun
(Address) 3136 Stafford St

15 Filed JUL 15 1922 H. A. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 14, 1922, that I last saw her alive on ....., 1922, and that death occurred, on the date stated above, at 5 30 am m.

The CAUSE OF DEATH* was as follows:

Malnutrition.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John F Aubrey, M. D.

, 19 (Address) 1629 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL July 15 1922

20 UNDERTAKER C. W. Dill.

ADDRESS 3109 Fredk. Ave.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65971

CERTIFICATE OF DEATH.

12-74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 226 N. Bradford ST.: 12 WARD)

2-FULL NAME Lewis Smith

(a) RESIDENCE. NO. 1517 Barclay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Smith

6 DATE OF BIRTH (month, day, and year) Unk 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Louisa Co. Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thelma Smith (Address) 226 N. Bradford St

15 Filed JUL 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1922 to July 12, 1922 that I last saw h[illegible] alive on July 12, 1922 and that death occurred, on the date stated above, at 8:25 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. W. C. Robinson, M. D.

7/13/22 (Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery DATE OF BURIAL July 15 1922

20 UNDERTAKER Wm Robert A Elliott ADDRESS 1725 Lakland St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65972

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 528 Tessier ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Robinson

(a) RESIDENCE. NO. 828 Tessier ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND ~~of~~ (or) WIFE of Dani Robinson

6 DATE OF BIRTH (month, day, and year) Mar 2, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Henrietta Speed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Lavinia Robinson (Address) 828 Tessier St

15 Filed JUL 15, 1922 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1922

17 I HEREBY CERTIFY, That I attended deceased from April 1922, to July 13th 1922, that I last saw her alive on July 13 1922, and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis Ch.
Interstitial Nephritis Ch

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Loss of Compensation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W Garrison Morris, M. D.

7/14 1922 (Address) 901 Mysic Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem DATE OF BURIAL July 16 1922

20 UNDERTAKER Wm Robert A Elliott & Leland Av ADDRESS 1725-

N. B.—WHILE PLAINLY WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 65973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65973

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 S. Kenwood Ave ST., 1 WARD)

2-FULL NAME John Thomas Schuppel

(a) RESIDENCE NO. 506 S. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER George H. C. Schuppel

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Evelina K. Padovel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant George H. C. Schuppel (Address) 506 S. Kenwood Ave

15 Filed JUL 15 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922. to July 13. 1922.

that I last saw him alive on July 12 1922

and that death occurred, on the date stated above, at 7 9. m.

The CAUSE OF DEATH* was as follows:

*Entero Colitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Bert Feller M. D.

7-13 1922 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL July 15 1922

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

156791 D 65974

HEALTH DEPARTMENT—CITY OF BALTIMORE D 65974

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jubb.

(a) RESIDENCE. NO. 215 N. Collington Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Jubb Mother.

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1921.

7 AGE: Years — Months 8 — Days 21. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child NO

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Jubb.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. Records (Address)

15 JUL 15 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 12, 1922, that I last saw h[illegible] alive on July 12, 1922, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urine examination —

(Signed) Horace G. Stewart, M. D.

7/13, 19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cem. DATE OF BURIAL: July 15 1922

20 UNDERTAKER: Maj. E. Evans & Son ADDRESS: 1520 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65975

CERTIFICATE OF DEATH.

90 D 65975

1-PLACE OF DEATH Bay View Hospital. Ward 1 is

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Jacob Hazelton

(a) RESIDENCE NO. 143 Aisquith ST., Bay View Asylum WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1844.

7 AGE — Years 78 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckester

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Kent Island, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant (Address) Miss Augustine Broadway 143 Aisquith Ave

15 Filed JUL 15 1922 Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1922 to 7-12, 1922, that I last saw him alive on 7-12, 1922, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic osteo-myelitis of left ankle

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic valvular heart disease

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 6-30-22

Was there an autopsy? —

What test confirmed diagnosis? Examination

(Signed) A. Richardson Jones M.D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL July 15 1922

ADDRESS .....

20 UNDERTAKER Samuel Beasley

ADDRESS 512 Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65976

D 65976

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 S. Stocton St. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Boone

(a) RESIDENCE No. 42. S. Stocton St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Negro

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Boone

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
32 plus ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Took in washing

(c) Name of employer Herself

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER William Burley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.

12 MAIDEN NAME OF MOTHER Lucy Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co.

14 Informant William Burley Jr.

(Address) 315 N. Gilmor St.

15 Filed JUL 15 1922. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/'22 19

17

I HEREBY CERTIFY, That I attended deceased from 7/8, 19 22, to 7/14/'22, 19

that I last saw her alive on 7/13/'22, 19

and that death occurred, on the date stated above, at 2:15 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of breast complicated with Mitral ins.

(duration) 1 yrs. 6 ?mos ds.

CONTRIBUTORY (Secondary) Broken compensation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam. and Hospital Report

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL July 16, 1922.

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 1114 W. Saratoga St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65977 (1568 1922 3:20 P.M.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 38 / 1 D 65977

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.: (Ward) 1 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Wilson

(a) RESIDENCE. No. Fairfield, Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of Hannah Wilson

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS
10 NAME OF FATHER Esau Wilson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922 to July 14, 1922 that I last saw him alive on July 14, 1922 and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Aneurysm of Aorta, Myocardial insufficiency* (duration) 4 yrs. apparx. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Xray + Autopsy

(Signed) Francis R. Dieudonné, M. D.

July 15, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Virginia — DATE OF BURIAL 7/15/22 19

20 UNDERTAKER Samuel N. Chesterson — ADDRESS 1400 Mosher St

* Probable Syphilis

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65978

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1332 Penna ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jennus

(a) RESIDENCE. NO. 1326 Penna ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbia S-C

PARENTS

10 NAME OF FATHER James Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) S-C

12 MAIDEN NAME OF MOTHER Laura Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S-C

14 Informant Laura Harris
(Address) 1522 Penna ave

15 Filed JUL 15 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9 1922 to July 14 1922

that I last saw her alive on July 14 1922 at 3 30 m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Chas F Hlauticz M. D.

July 15 1922 (Address) 1504 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 7/16/22 19

20 UNDERTAKER Samuel W Chase-sm

ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL ITEMS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

65979 D 65979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

007 65979 X/18 D 65979

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hosp St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Freckendorf-

(a) RESIDENCE. No. Laurel Md St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 24-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~...~~	~~(9 2)~~	~~...~~	2 days ~~24~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infirm pld

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER W Freckendorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Fricke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant C Freckendorf (Address) Laurel Md.

15 Filed JUL 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14 1922

17 I HEREBY CERTIFY, That I attended deceased from 7-14, 1922, to 7-14, 1922, that I last saw ~~him~~ alive on 7-14, 1922, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Laurel Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C A Tompkins, M. D.

, 19 (Address) Md General Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	Jul 17 19 22
20 UNDERTAKER	ADDRESS
Geo O French	Laurel

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

157619 D 65980 65980 — X 45 D 65980 — 65980

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jackson Maxwell

(a) RESIDENCE. NO. Fuches, N. C. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Lillie Maxwell (wife),

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. 06

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Richmond Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Robb Maxwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL. Records (Address)

15 Filed JUL 16 1922 ROBERT T. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1922.

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 15, 1922, that I last saw him alive on July 15, 1922, and that death occurred, on the date stated above, at 1 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fuches N.C.

Did an operation precede death? Yes Date of July 15-1922

Was there an autopsy? No

What test confirmed diagnosis? Examination of tissue

(Signed) Warfield M. Firor M. D.

15 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Maxwell Cemetery, N.C. DATE OF BURIAL: July 15-1922

20 UNDERTAKER: Jno Robert T Elliott ADDRESS: Ashland Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

65981 D 65981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 65981 D 65981

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Garrett. ave St., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Faul

(Residence in Baltimore: No. 1719 Garrett. ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Dec 15, 1851 (Month) (Day) (Year)

7-AGE, 70 yrs. 6 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Housewife

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Ackerman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Faul

(Address) 1719 Gorsuch Ave

15- Filed JUL 16 1922, 191... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 14, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1922, to July 14 1922, that I saw her alive on July 13 1922, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Abscess Nephritis

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ....yrs. ....mos. 7 ds.

(Signed) J. M. Lumpkin M. D.

July 15, 1922 (Address) 426 N. Arlington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Jerusalem

DATE OF BURIAL, 7/17/22, 191...

20-UNDERTAKER George J. Ruth

ADDRESS 1731 Hanover Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65982

CERTIFICATE OF DEATH.

91-00 D 65982

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 E Preston ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William De Huff

(a) RESIDENCE NO. 713 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elizabeth De Huff

6 DATE OF BIRTH (month, day, and year) August 13th 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Corpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York Co (State or country) Pa.

PARENTS

10 NAME OF FATHER George DeHuff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Rupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs Alice Hiestand

(Address) 713 E Preston st

15 Filed JUL 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15th 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922, to July 15th, 1922, that I last saw him alive on July 15th 8 a m, 1922, and that death occurred, on the date stated above, at 830 a m.

The CAUSE OF DEATH* was as follows:

Senility

(Chronic Arteriosclerosis)

(duration) May yrs. mos ds.

CONTRIBUTORY (Secondary) Heart Thrombosis & Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical History

(Signed) Wilmer Brinton M. D.

, 19 (Address) S.W. Cor. Calvert & Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Pa DATE OF BURIAL July 17th 1922

20 UNDERTAKER George J Schilling & Sons ADDRESS 126 E Main St

Spec.—1-10-21—M&T—1500 Bks.

Brenner. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65983

CERTIFICATE OF DEATH.

179 D 65983

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 E. Lombard St., 3 WARD)

2-FULL NAME Morris Fishel Brenner

(a) RESIDENCE NO. 915 E. Lombardt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Brener

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 64 | Months — | Days — | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Grocerie 045

(c) Name of employer: Merchant

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1431 E Baltimore

15 Filed JUL 16 1922 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to June 12, 1922, that I last saw him alive on June 12, 1922, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Signs & Laboratory findings

(Signed) Harry H. Kaufmann M. D.

, 19 (Address) 2329 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrenberg Rem | DATE OF BURIAL: July 16 1922

20 UNDERTAKER: Jack Lewis | ADDRESS: 1439 E Balt

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65984

D 65984

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1423 N Bruce ST., 15 WARD)

2-FULL NAME Lucy Ann Pitts

(a) RESIDENCE NO. 1423 N Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Ed. Pitts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Brockbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs A. Pitts

(Address) 1423 Bruce St

15 Filed JUL 16 1922, 19 ROBERT R. KNABE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 14, 1922, that I last saw h[illegible] alive on July 14 1922, and that death occurred, on the date stated above, at 8 AM m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Poorly nourished 7 mos

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible symptoms

(Signed) [illegible] M. D.

(Address) 1600 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL July 16 19 22

20 UNDERTAKER [illegible] ADDRESS 1 31 2

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

65985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

D 65985

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. 8 ST., 15 WARD)

2-FULL NAME Mable Washington

(a) RESIDENCE NO. 1426 N. Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE — Years: 20 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti. Md

PARENTS

10 NAME OF FATHER James Cephas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balti Md

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Arthur Cephas (Address) 212 Baker St

15 Filed JUL 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922 to July 13, 1922

that I last saw her alive on July 13, 1922

and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Tubo ovarian abscess on left side due to streptococcus origin.

(duration) yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia & generalized Septaemia (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 7-6-22

Was there an autopsy? .....

What test confirmed diagnosis? Examination

(Signed) ..... M.D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt Auburn — DATE OF BURIAL July 16 1922

20 UNDERTAKER James N. Lewis — ADDRESS 1313 Freeman

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 65986

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Ethel ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund Hadley

(a) RESIDENCE. NO. 210 Ethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 1903

7 AGE: Years | Months: 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Edw. Hadley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Edw. Hadley (Address) 210 Ethel St

15 Filed JUL 16 1922 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/15 1922

17

I HEREBY CERTIFY, That I attended deceased from 7/11 . 1922 . to 7/15 . 1922

that I last saw h alive on 7/15 . 1922

and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Ac. Obstruction - Acute Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Litter M. D.

. 19 (Address) 235 Dk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 16 1922
20 UNDERTAKER: James H. Ames	ADDRESS: 318 Gilmor

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65987

CERTIFICATE OF DEATH

D 65987

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE—No. ..... ST. ..... WARD)

2-FULL NAME Beatrice O. Saenz.

(a) RESIDENCE NO. 39 Gorsuch Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Louis Saenz.

6 DATE OF BIRTH (month, day, and year): 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Joseph Cost.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Bayview Hospital Balto, Md.

15 JUL 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 14, 1922, that I last saw h[illegible] alive on July 14, 1922 and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Fredsmith, M. D.

7/15/1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mountain Cemetery — DATE OF BURIAL: July 17 1922

20 UNDERTAKER: George E. Schmidt — ADDRESS: 1401 Eutaw

George L. Marley. ✓

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65988

CERTIFICATE OF DEATH.

100-001 D 65988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S. Payson ST., 20 WARD)

2-FULL NAME George Leads Marley

(a) RESIDENCE NO. 318 S. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar 29 1921

7 AGE: Years 1 Months 3 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Elmer L. Marley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah J. Moon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Elmer L. Marley (Address) 318 S. Payson St

15 Filed JUL 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to July 13, 1922.

that I last saw h— alive on July 13, 1922

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James L. Hutchinson M. D.

7/15, 1922 (Address) 1729 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 17 1922

20 UNDERTAKER: George L. Schnaderbeck — ADDRESS: 1101 Eutaw Pl

Spec.—6-9-19—H. P. Co.—1000 Bks.

156844

D 65989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 65989

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Fourney

(a) RESIDENCE. No. 101 Pine St. Williamsport, Pa. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Eugenie Fourney (wife)

6 DATE OF BIRTH (month, day, and year) July 26, 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Prop.

(b) General nature of industry, business, or establishment in which employed (or employer) O&C

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10 NAME OF FATHER Francis Fourney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Lucy Mercer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed JUL 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to July 16, 1922, that I last saw him alive on July 16, 1922, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate

Anuria for

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pa.

Did an operation precede death? Yes Date of 7-14-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. P. Johnson, M. D.

16, 1922 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Williamsport Pa. DATE OF BURIAL July 16 1922

20 UNDERTAKER Joseph Ahrens ADDRESS 221 B Way

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65990 ✓ 113 D 65990

CERTIFICATE OF DEATH.

D 65990

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Archer ST., 21 WARD)

2-FULL NAME Warren H. Palmer

(a) RESIDENCE NO. 603 Archer ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Apr 10-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Elmona Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elmona Palmer (Address) 603 Archer St

15 JUL 16 1922 ..... Registrar

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9th, 1922, to July 14th, 1922, that I last saw h[illegible] alive on July 14th, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Intoxication

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

7/15, 1922 (Address) 140 W. Dallas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL July 16 1922

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Uhler St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 65991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 65991

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.: 71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Parker

(a) RESIDENCE. NO. Provident Hospital ST. WARD.
(Usual place of abode) 1425 Ward 11
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): 42 years ago

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	7th	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Norfolk Va.

PARENTS

10 NAME OF FATHER: Edmund Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Husband
(Address): 1425 Ward

15 JUL 16 1922 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922, to July 12, 1922, that I last saw her alive on July 12, 1922, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) A. W. Fisher M. D.

, 19 (Address) 912 S. Mary's St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: July 16 1922

20 UNDERTAKER: John H. Tradin — ADDRESS 142 Ostend St

Shivers ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

65992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1329 D 65992

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene Sts. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Shivers

(a) RESIDENCE. NO. 28 Cordale Ave. Hamilton WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elvira Shivers

6 DATE OF BIRTH (month, day, and year) June 10 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None DOD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Peter Shivers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Shivers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant C. C. Hoffman (Address) 28 Cordale Ave. Hamilton Md.

15 Filed JUL 16 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15 1922.

17 I HEREBY CERTIFY, That I attended deceased from 7/12, 1922, to 7/15, 1922, that I last saw him alive on 7/15, 1922 and that death occurred, on the date stated above, at 6 45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.
Chronic Nephritis

(duration) 2. yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & clinical findings

(Signed) Jno. Deaver Hall M.D.

7/15, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 17 1922
20 UNDERTAKER Joseph B. Cork	ADDRESS 1003 W. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65993

CERTIFICATE OF DEATH.

113 D 65993

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 405 S Castel ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elenore Jorechi

(a) RESIDENCE. No. 405 S Castel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None pd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph A Jorechi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elenore Banach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Castel Delaware

14 Informant (Address) Joseph A Jorechi 405 S Castel St

15 Filed JUL 16 1922 ROBERT H. KRAUTER, Registrar Burial Permit C[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15 1922 to July 15 1922, that I last saw her alive on July 15 1922, and that death occurred, on the date stated above, at 730 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Tumblesom, M. D.

7/16 1922 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	July 17 1922

20 UNDERTAKER John A Weber ADDRESS 1803 Bank

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65994

CERTIFICATE OF DEATH.

113

D 65994

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1908 Bank St- ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gonglewski

(a) RESIDENCE. NO. 1908 Bank ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Gonglewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Nadolny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frances Nodolny

(Address) 1908 Bank St

JUL 16 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1922, to July 15, 1922, that I last saw him alive on July 14, 1922, and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Thos. F. A. Lewis, M. D.

7/15, 1922 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 16 1922

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Cecelia C. Heisterman ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65995 ✓ 45 D 65995

CERTIFICATE OF DEATH.

D 65995

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... St.: 70 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. William Heisterman

(a) RESIDENCE. No. 2709 Boone St., Ward. McDonough, Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Heisterman

6 DATE OF BIRTH (month, day, and year) July 4th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William A. Heisterman (Address) McDonough Md

15 Filed JUL 16 1922 ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15th, 1922

17

I HEREBY CERTIFY, That I attended deceased from April 11th, 1922, to July 15th, 1922, that I last saw her alive on July 13th, 1922, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, mesenteric cyst & general abdominal metastases

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes, (General) Date of last, July 15th, 1922

Was there an autopsy? no

What test confirmed diagnosis? Operation & microscopical exam.

(Signed) John F. Finney J. M. D.

July 15th 1922 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemtry

DATE OF BURIAL: 7/18 1922

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65996 | D 65996

CERTIFICATE OF DEATH.

X 100-00

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No Turners Station ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna LeBoy

(a) RESIDENCE. NO. Turner's Station, Md. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 week ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Deboy.

6 DATE OF BIRTH (month, day, and year) July 10-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57 yrs.	57	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) John F. Deboy Turners Sta. Balto. Co. Md.

15 Filed JUL 16 1922 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 15, 1922, that I last saw h-r alive on July 15, 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Toxemia of Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Ten days Broncho-Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Turners Station

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Moses Gelman, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	7-17 1922
20 UNDERTAKER	ADDRESS
William Cook C.	602 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 V

D 65997

D 65997

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Wyanoke Ave St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Marshall

(a) RESIDENCE. No. 612 Wyanoke Ave St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Samuel Marshall

6 DATE OF BIRTH (month, day, and year): 2-19-1843

7 AGE: Years 79; Months 4; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: William Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co Md

12 MAIDEN NAME OF MOTHER: Sarah A. Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Eunice Butler

(Address): 612 Wyanoke Ave

15 Filed JUL 18 1922 19 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6 1922, to July 14, 1922, that I last saw her alive on July 14, 1922, and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis with cerebral hemorrhage.

Hemiplegia, left side (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) H. E. Wright, M. D.

7/14 1922 (Address) 1202 N. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: 7/17 192

20 UNDERTAKER: William Cook — ADDRESS: Solemn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

65998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65998

CERTIFICATE OF DEATH.

129 D 65998

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Madison Ave., ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Albert

(a) RESIDENCE No. 710 Madison Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel A. Albert

6 DATE OF BIRTH (month, day, and year) ---------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	78	---	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) Rochester, N. Y. (State or country)

PARENTS

10 NAME OF FATHER John Fitzgibbon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Victor J. Albert

(Address) 710 Madison Ave.

15 Filed JUL 17 1922, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15. 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1922, to July 15, 1922, that I last saw her alive on July 15, 1922 and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pettigrew, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rochester, N. Y. DATE OF BURIAL: 7/18/22 19

20 UNDERTAKER: Henry W. Mears & Son, ADDRESS 805 N. Calvert

Via Penn. R. R. -- Victor J. Albert, Escort.

Spec.—1-10-23—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 65999

CERTIFICATE OF DEATH.

57

D 65999

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 17 WARD)

2-FULL NAME Mary Arthur

(a) RESIDENCE NO. 825 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Anna Arundel Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Alice Green
(Address) 825 Franklin St

15 Filed JUL 17 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14 1922

17 I HEREBY CERTIFY, That I attended deceased from 7-14, 1922 to 7-14, 1922 that I last saw her alive on 7-14, 1922 and that death occurred, on the date stated above, at 10⁴⁵ A.m.

The CAUSE OF DEATH* was as follows:

Gangrene of right foot
Of Diabetic Origin

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Nephritis, generalized arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J Richardson Jones M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	July 17 1922
20 UNDERTAKER	ADDRESS
S. L. Brown's Son	Woodlawn Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15699
5 30 P.M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66000

CERTIFICATE OF DEATH.

113

D 66000

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD)

2-FULL NAME Concercion Matthew

(a) RESIDENCE. NO. 1627 Thames St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) March 1 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Matthew

11 BIRTHPLACE OF FATHER (city or town) Spain
(State or country)

12 MAIDEN NAME OF MOTHER Concercia?

13 BIRTHPLACE OF MOTHER (city or town) Spain
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 17 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17

I HEREBY CERTIFY, That I attended deceased from July 6 1922, to July 14, 1922, that I last saw h e alive on July 14, 1922, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery?)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine exam. & Pathalogic

(Signed) Horace G. Stewart, M. D.

7/15, 19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	July 17 1922
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66001

CERTIFICATE OF DEATH.

194 D 66001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Milliman ST.; 7 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. A. Brown

(Residence in Baltimore: No. 1636 Milliman St. 19 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, March (Month) 27 (Day), 1857 (Year)

7-AGE, 65 yrs. 3 mos. 17 ds.

If LESS than 1 day, ... hrs. or ... mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Warren Co N.C.

PARENTS.

10-NAME OF FATHER, Joseph Brown

11-BIRTHPLACE OF FATHER (State or Country), Warren Co N.C.

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife Lucie Brown

(Address) 1635 Milliman St

15-

Filed JUL 17 1922, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1922, to July 14 1922, that I saw him alive on July 14 1922, and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Heat Stroke

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion & Coma

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Alf S. Sagl M. D.

July 17, 191... (Address) 709 N. Edward...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Port Mouth Va — DATE OF BURIAL, July 18, 1922

20-UNDERTAKER, Jno Robert-A Elliott — ADDRESS 725 Fakland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66002

CERTIFICATE OF DEATH.

49

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John H. Spriggs

(a) RESIDENCE. NO. 1424 Hopkins Place ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Nov 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co., Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 FILED JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20. 1922. to July 14. 1922.

that I last saw him alive on July 14. 1922.

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde M. Reid, M. D.

7/15/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 17th 1922
20 UNDERTAKER	ADDRESS
Laurence E. Wright	1364 W. Conway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 66003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1129 St Fulton Ave. 16 WARD)

2-FULL NAME William Mc Elroy

(a) RESIDENCE. No. 1129 St Fulton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? 80 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~ Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or WIFE of) Elizabeth Mc Elroy

6 DATE OF BIRTH (month, day, and year) June 13 1836

7 AGE: Years 86 | Months — | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: John Mc Elroy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Nancy Mc Cracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Gertie Buck

(Address): 1129 St Fulton Av

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 16, 1922, that I last saw him alive on July 16, 1922, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas T. McCarthy, M. D.

(Address) 906 N. Stricker St

JUL 18 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: JUL 19 1922

20 UNDERTAKER: Geo W Little

ADDRESS: 2700 Edmondson Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 66004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66004

CERTIFICATE OF DEATH.

34

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. University Hospital. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARGARET MINETTA START

(a) RESIDENCE. No. 3209-N-Charles-St. ST., 12 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? 62 yrs. 10 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amos Gregory Start.

6 DATE OF BIRTH (month, day, and year) Sept-14-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Henry W. Classen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Unetta Schier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Amos G. Start, (husband) 3209-N-Charles-St., City.

15 Filed JUL 17 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15 22.

17 I HEREBY CERTIFY, That I attended deceased from 4/17/22, 19 , to 7/15 , 19 22

that I last saw h alive on 7/15 , 19 22.

and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Otitis I body I 3rd Lumbar Vertebra

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy & clinical findings

(Signed) Thos Jordan M. D., M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREENMOUNT CEMETERY

DATE OF BURIAL: July-18-22

20 UNDERTAKER: STEWART & MOWER

ADDRESS: [redacted] N. NORTH AVE.

• MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66005 D 66005

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1643-N-Calvert ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bourne Parran

(a) RESIDENCE. No. 1643-N-Calvert ST. 12 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 66 yrs. 3 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeanette Briscoe Parran

6 DATE OF BIRTH (month, day, and year) March-27-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer Dan'l Miller Co.

9 BIRTHPLACE (city or town) (State or country) Calvert Co Maryland

PARENTS

10 NAME OF FATHER Wm. J. Parran

11 BIRTHPLACE OF FATHER (city or town) St Leonard (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Sarah R. Bourne

13 BIRTHPLACE OF MOTHER (city or town) Solomons (State or country) Calvert Co. Md.

14 Informant Mr. Wm. J. Parran (brother)

(Address) 1708 N. Calvert St. City

15 Filed JUL 17 1922 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-14-1922.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10- , 1922 , to July 14 , 1922 .

that I last saw him alive on July 14 , 1922 ,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 2 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyloric obstruction

Emaciation (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M D Wise , M. D.

, 19 (Address) 1800 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July-17 1922

20 UNDERTAKER STEWART & MOWER COMPANY (WILLIAM F. WOODS, Secretary)

ADDRESS 100 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 66006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66006

CERTIFICATE OF DEATH.

114

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 624 Scott ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Wagner

(Residence in Baltimore: No. 624 Scott St.; 2 yrs., 1 mos. X ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 7 (Month) (Day) 1838 (Year)

7-AGE, 41 yrs. 5 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Wagner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Christine Dack

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Wagner

(Address) 624 Scott

15- JUL 17 1922

Filed....., 191.... E Wehn Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1922, to July 16 1922, that I saw h— alive on July 15 1922, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) John G Schwensberg M. D.

July 17 1922 (Address) 1176 W Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, July 18 1922

20-UNDERTAKER Knell & Son — ADDRESS 1229 W Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66007

D 66007

49

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 651 Bloom ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Louise Frazier

(a) RESIDENCE. No. 651 Bloom ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stewart H. Frazier

6 DATE OF BIRTH (month, day, and year) Nov 5-1892.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	29	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair Dresser

(b) General nature of industry, business, or establishment in which employed (or employer) Hair Dressing Off

(c) Name of employer —

9 BIRTHPLACE (city or town) Accomac Co
(State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Watson

11 BIRTHPLACE OF FATHER (city or town) Accomac Co
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Maywood

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co
(State or country) Virginia

14 Informant Stewart H. Frazier
(Address) 651 Bloom St

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1922, to July 13, 1922, that I last saw her alive on July 13, 1922, and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder and Kidneys

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Dec 14-1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Burwell Fauntleroy, M. D.

7-15 1922 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 17 1922
20 UNDERTAKER	ADDRESS
Wm. H. Clise & Son	1900 W. Lafayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 66008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66008

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1410 E Lexington ST., 9 WARD)

2-FULL NAME Anna Gritzan

(a) RESIDENCE NO. 1410 E Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60,	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berlin Md

PARENTS

10 NAME OF FATHER Adam Gritzan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Schuberlein.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mollie Gritzan
(Address) 1410 E Lexington

15 Filed JUL 17 1922 G G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to July 15 1922.

that I last saw h. alive on July 14, 1922.

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion &
Toxaemia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Felt it.

(Signed) Claud Smith M. D.

19 22 (Address) 4 W Hoffman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Berlin Cemetery

DATE OF BURIAL 7/18/1922

20 UNDERTAKER E J Wenning & Son

ADDRESS 1438 N Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

D 66009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66009

CERTIFICATE OF DEATH.

70

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dakes

(a) RESIDENCE NO. Middle River, Bergis P.O. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 16 1885

7 AGE Years 36 Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Rail Road

(c) Name of employer Pennsylvania R.R.

9 BIRTHPLACE (city or town) Bosnia (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia Vanik

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country) Austria

14 Informant Joseph Sellers (Address) Middle River Md.

15 Filed JUL 17 1922, 19 J E Mohn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16 1922

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1922, to July 16, 1922, that I last saw him alive on July 16, 1922 and that death occurred, on the date stated above, at 10.50 A m.

The CAUSE OF DEATH* was as follows:

Abscess of Brain

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) General Septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings

(Signed) Marlow L Pace, M. D.

7/18, 1922 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zion Lutheran Cemetery — DATE OF BURIAL: July 18 1922

20 UNDERTAKER: Frank Lasasso Sons — ADDRESS: Fallston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66010 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66010

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S Duncan ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Kurzya

(a) RESIDENCE NO. 420 S Duncan ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Kurzya

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Posniatowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Helen Kurzya
(Address) 420 S Duncan

15 Filed JUL 17-1922, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1922.

17 I HEREBY CERTIFY That I attended deceased from July. 11 ....., 1922, to July 16. 1922

that I last saw h[illegible] alive on July 15 1922

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Tubes Colitis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rynex, M. D.

19 [illegible] (Address) 80[illegible] Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL July 18 1922

20 UNDERTAKER John M Reber — ADDRESS 1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66011 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66011

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 E. 20th St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles. W. Voegelein

(a) RESIDENCE NO. 512 E. 20th St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mrs. Lula. E. Voegelein

6 DATE OF BIRTH (month, day, and year) Sept.-27-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Charles. W. Voegelein

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Katharine Arnold

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Lula. E. Voegelein (Address) 516 E. 20th St

15 Filed JUL 17 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-16-1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1921, to July 16, 1922, that I last saw him alive on July 15, 1922, and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Not Definite mos. ds.

CONTRIBUTORY (Secondary) Enhancement (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Benj. D. Hamilton M. D.

7/17, 1922 (Address) 1216 N. Castle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July-18-1922

20 UNDERTAKER Henry Stockdale ADDRESS 1301 E Eager

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66012

CERTIFICATE OF DEATH.

D 66012

REGISTERED NO. 974-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1338 Harford Ave. (St.) (Ward) 9

2-FULL NAME Thomas. J. Maskell

(a) RESIDENCE NO. 1338 Harford Ave (St.) (Ward)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 40 yrs. -- mos. -- ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Anna. C. Maskell

6 DATE OF BIRTH (month, day, and year) March-4-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman for Balto. City

(b) General nature of industry, business, or establishment in which employed (or employer) Water department

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Maskell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Anna C Maskell
(Address) 1338 Harford Ave

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-15-1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1921, to July 15, 1922, that I last saw h alive on July 15, 1922, and that death occurred, on the date stated above, at 10:45 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about 3 hrs.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis, Arterio-Sclr.

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leonard H. Morrison, M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL July-18-19

20 UNDERTAKER Henry Hirch & Son — ADDRESS 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

D 66013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66013

CERTIFICATE OF DEATH.

74-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1976 Belair Road. ST., 8 WARD)

2-FULL NAME Mary Parlett

(a) RESIDENCE NO. 1976 Belair Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 67 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Henry. J. Parlett

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	About 68	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Parlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Leahy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Daniel H. Parlett.

(Address) 2614 E Oliver St

15 Filed ..... 19 ..... Registrar

JUL 17 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-16-1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 16, 1922.

that I last saw her alive on July 16, 1922.

and that death occurred, on the date stated above, at 1:40 A.m.

The CAUSE OF DEATH* was as follows:

Paralysis (apoplexy)

(duration) ..... yrs. mos 20 ds.

CONTRIBUTORY (Secondary) senility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. J. McGuigan, M. D.

7/16, 1922 (Address) 1266 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July-18-19

20 UNDERTAKER Henry Woelk Son

ADDRESS 1301 E Eager St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

(over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66014

CERTIFICATE OF DEATH.

179 D 66014

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 176 S. Ann St. ST., 7 WARD)

2-FULL NAME William Howard Mason.

(a) RESIDENCE NO. 176 S. Ann St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 25-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	5	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) md.

PARENTS

10 NAME OF FATHER William H. Mason.

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) md.

12 MAIDEN NAME OF MOTHER Annie Wyman

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) md.

14 Informant Annie Mason

(Address) 176 S. Ann St.

15 JUL 17 1922 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1922, to July 15, 1922, that I last saw h alive on July 15, 1922, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows: Shock from Burst left side • apelix (Hatches)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(over)

(Signed) J. Wenkin, M. D.

July 15, 1922 (Address) 1 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL July 17 1922

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Woll St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66015

HEALTH DEPARTMENT—CITY OF BALTIMORE

1130 66015

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33 Wheeler Ave. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Gross O'Hara

(a) RESIDENCE. No. 33 Wheeler Ave ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 15 ds. How long in U. S., If of foreign birth? — yrs — mos. — ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 1, 21.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James C. O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mildred Brill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mildred Brill (Address) 33 Wheeler Ave

15 Filed JUL 18 1922 F. E. Cohn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 '22

17

I HEREBY CERTIFY, That I attended deceased from July 8, 1922, to July 15, 1922, that I last saw h alive on , 1922, and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Coolahan, M. D.

7/15 1922 Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	July 17 '22

20 UNDERTAKER F. B. Keppler ADDRESS 2236 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66016

CERTIFICATE OF DEATH.

D 66016

REGISTERED NO. 1125

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 74 E Henrietta ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Ellsworth Woods

(a) RESIDENCE. No. 74 E Henrietta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1.10.22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Frank Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alt Co. Md.

12 MAIDEN NAME OF MOTHER Ethel Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Ethel Woods (Address) 74 E Henrietta St

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7.16 1922

17 I HEREBY CERTIFY, That I attended deceased from 6.24, 1922, to 7.16, 1922; that I last saw h in alive on 7.16, 1922; and that death occurred, on the date stated above, at 12.30 am

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Gen Debility From Birth (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. Burlington, M. D.

7.16 1922 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL July 17 1922

20 UNDERTAKER F. C. Frame & Son — ADDRESS 1039 Fairmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 66017 ✓ D 66017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S.Castle ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN PLACEK,

(a) RESIDENCE NO. 319 S.Castle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred I yrs. I mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16-1921.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
I	I	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, ~~0~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Joseph Placek,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, MD.

12 MAIDEN NAME OF MOTHER Julia Rok,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Julia Placek, (Mother)
(Address) #319 S.Castle Street

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16. 1922.

17 I HEREBY CERTIFY, That I attended deceased from July 14, 19 22, to July 16, 19 22,

that I last saw h— alive on July 16, 19 22,

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Colitis

Infantile

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem., DATE OF BURIAL July 17- 1922.

20 UNDERTAKER M. J. Sadowski. ADDRESS 705 S. Ann St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66018

CERTIFICATE OF DEATH.

167 D 66018

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 N. Caroline ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Clarke

(a) RESIDENCE. No. 1617 N. Caroline ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grain Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary Shaw
(Address) 1617 N. Caroline St.

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3 1922, to July 15 1922, that I last saw him alive on July 15 1922, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Infirmities of age

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? aged at 1617 Caroline

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R O Carman, M. D.

7 16 1922 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 17, 1922

20 UNDERTAKER Chas. G. Evans & Son ADDRESS 1524 N. Howard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-66919

CERTIFICATE OF DEATH.

36-003 D 66919

1-PLACE OF DEATH Municipal Hospital

CITY OF BALTIMORE: (No. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Emory

(a) RESIDENCE NO. 539 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

"FEED FOR BINDING"

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Queen Anne Co., Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Hosp. Records

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15-1922

17 I HEREBY CERTIFY, That I attended deceased from 7-5-1922 to 7-15-1922

that I last saw h alive on 7-15-1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis (duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Genito-Urinary Tuberculosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde McNeal M. D.

7/15, 1922 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Md	July 18 1922
20 UNDERTAKER	ADDRESS
A. E. Brown & Son	1711 Madison Ave

Ave Fourth Ward

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 66020 — PLACE OF DEATH

113 — D 66020 — REGISTERED No. C

CITY OF BALTIMORE (No. 1035 Greenmount Ave ST. 10 WARD)

(If death occured i a hospital or institution give its NAME instead o street and number an fill out No. 18.)

2-FULL NAME Thomas W. Meredith

(Residence in Baltimore: No. 1035 Greenmount Ave St.: yrs. 3 mos. ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: whit

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April (Month) 12 (Day), 1922 (Year)

7 AGE: yrs. 3 mos. 4 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Non
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9 BIRTHPLACE (State or country): Balto City

PARENTS

10 NAME OF FATHER: Eskel Meredith

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Dunn

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eskel Meredith

(Address) 1035 Greenmount Ave

15 JUL 17 1922 [19] — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 16 (Day), 192[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 192[illegible] to May 16 192[illegible]

that I saw h[illegible] alive on May 16, 192[illegible]

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cardio Enteritis

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Enteritis Colitis

(Duration) yrs. mos. 10 ds.

(Signed) James M Fenby M. D.

July 17, 192[illegible] (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death: yrs. mos. ds. — In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Vincents Cemetery — DATE OF BURIAL: 7 17 192[illegible]

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66021

CERTIFICATE OF DEATH.

129 D 66021

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 North Fulton Ave ST., 20th WARD)

2-FULL NAME William Mayberry Atkinson

(a) RESIDENCE NO. 322 North Fulton Ave ST., 20th WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Mary Ellen

6 DATE OF BIRTH (month, day, and year) May 11th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	64	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Lieut Detective

(b) General nature of industry, business, or establishment in which employed (or employer): Balto Police Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Allan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Sarah McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Hamilton R Atkinson

(Address) 322 N Fulton Ave

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922 to July 15, 1922

that I last saw h— alive on July 15, 1922

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Cerebral Embolism

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Hypertension (duration) yrs. 10 mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H R Atkinson, M. D.

July 16, 1922 Address 1724 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 18 1922
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

D 66022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C 1629

City of BALTIMORE: (No. Mercy Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benj Williams

(Residence in Baltimore: No. 1120 Vincent St.; 19 yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: June (Month) 24 (Day) 1912 (Year)

7-AGE: 10 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): B. C.

PARENTS.

10-NAME OF FATHER: Benj Williams

11-BIRTHPLACE OF FATHER (State or Country): B. City.

12-MAIDEN NAME OF MOTHER: Alexis Isaacs

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benj Williams

(Address) 1120 Vincent

15- JUL 18 1922 Registrar.

(Date) July 18 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 14 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Sclerosis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Shot by a blank Cartridge

(Duration) yrs. mos. 10 ds.

(Signed) H K Grimes M. D. (Coroner)

July 15 1922 (Address) H K Grimes

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: July 18 1922

20-UNDERTAKER: Edward Dr Fan — ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

D 66023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66023

91-002

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 E. 20th St., 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel B Lester.

(a) RESIDENCE No. 334 E 20th (Usual place of abode) St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah A. Lester

6 DATE OF BIRTH (month, day, and year): Jan 24-1853

7 AGE: Years 69 Months 5 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 631

(b) General nature of industry, business, or establishment in which employed (or employer): Machinist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Levi Lester.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westminster.

12 MAIDEN NAME OF MOTHER: Lydia Seward Died 1918

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: E. Kathryn Lester (Address) 3248 Gwynns

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1922, to July 15, 1922, that I last saw h alive on July 15, 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

General Arterio-sclerosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmitt M. D.

(Address) 701 Hendwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md. DATE OF BURIAL: July 17 1922

20 UNDERTAKER: H. J. Tschudy & Son ADDRESS: North Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66024

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-D 66024

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N. Carrollton St. Ave. 16 WARD)

2-FULL NAME Sarah Markland

(a) RESIDENCE. No. 711 N. Carrollton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 17-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. T. Markland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alford Mass.

12 MAIDEN NAME OF MOTHER Jane P. Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Wm. T. Markland Jr. (Address) 711 N. Carrollton Ave

15 Filed JUL 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922, to July 16, 1922, that I last saw her alive on July 16, 1922, and that death occurred, on the date stated above, at 10-45-A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL July 8 1922

20 UNDERTAKER Wm. J. Tuckerbens ADDRESS North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66025

161-001

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Hollins ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Soveria Joseph Scallio

(a) RESIDENCE NO. 1137 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (a) HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 16 1922

7 AGE: Years —; Months —; Days 2; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0D

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Salvil Scallio

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Louise Scallio

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Samuel Scallio

(Address) 1137 Hollins St.

Filed JUL 17 1922

H A Moore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to July 16, 1922, that I last saw him alive on July 16, 1922, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Asphyxia due to premature birth of 7 month pregnancy (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine, M. D.

July 17, 1922 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 7-18 1922

20 UNDERTAKER: ROBERT BROOKS & SON — ADDRESS: 19 S Calhoun

FUNERAL DIRECTORS & EMBALMERS

Spec.—1-10-21—M&T—1500 Bks.

Shipway ✓

D 66026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66026

CERTIFICATE OF DEATH.

X66

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME William Shipway.

(a) RESIDENCE NO. 48 Market Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Feb. 23 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64 yrs.	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk, Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: William Shipway

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Rebecca Tunney.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant (Address): Arthur T. Shipway Camden, N. J.

15 Filed JUL 17 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1922, to July 14, 1922, that I last saw him alive on July 14, 1922, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sym & Signs.

(Signed) V. J. Pasagnus, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: 7/20/19 22

20 UNDERTAKER: Wm Leech, 50 E Monument ADDRESS

Burial Permit Clerk.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66027

CERTIFICATE OF DEATH.

5 113 D 66027

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N. High St. ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby - Pearl Carter.

(a) RESIDENCE. No. 421 N. High ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Female X	Black	Baby

5a If married, widowed, or divorced ~~HUSBAND~~ of (or ~~WIFE~~ of)

6 DATE OF BIRTH (month, day, and year) June 22nd 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimor. Md.

PARENTS

10 NAME OF FATHER Jacob McKachem

11 BIRTHPLACE OF FATHER (city or town) Roswell (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Virginia Carter

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia.

11 Informant (Address) Johns Hopkins Hospital Records.

15 Filed JUL 17 1922 . 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 22nd 1922, to July 16th 1922, that I last saw her alive on July 16th 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) F. F. Cathrall. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	July 18 1922
20 UNDERTAKER	ADDRESS

Commissioner of Health.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 66028

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: 19 WARD)

2-FULL NAME Mary Washington

(a) RESIDENCE. No. 1009 N. Stricker St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ ~~(or) WIFE~~ of Gladys Washington (Mother)

6 DATE OF BIRTH (month, day, and year) April 5, 1922

7 AGE — Years | 3 Months | 8 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Joe Robinson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ?

12 MAIDEN NAME OF MOTHER: Gladys Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 Filed JUL 17 1922, 19..... ROBERT R. KRAUTER Clerk.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13, 1922.

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1922, to July 13, 1922, that I last saw her alive on July 13, 1922, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis, early hereditary

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pertussis

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Wasserman report not in

What test confirmed diagnosis? W.R.C. 120,000 50% C.M.

(Signed) Horace D. Stewart, M. D.

July 13, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: July 15 1922

20 UNDERTAKER

ADDRESS

19365

Spec.—1-10-21—M&T—1500 Bks.

D 66029 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66029

Gall

CERTIFICATE OF DEATH.

161-004

1-PLACE OF DEATH St Vincents Infr Asy. REGISTERED NO.

CITY OF BALTIMORE: (No. 1401 Division ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Gall

(a) RESIDENCE NO. 1401 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14, 1922

7 AGE: 1 Day (Years / Months / Days: 1) If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank Durkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Ruth Gall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant St Vincent Infy Asy (Address) 1401 Division

15 JUL 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922, to July 14, 1922, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Premature birth (4 lbs).

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem DATE OF BURIAL: July 17 1922

20 UNDERTAKER: Merlin Hafey & Sons ADDRESS: 1821 W North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66030

CERTIFICATE OF DEATH.

36-003

D 66030

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2602 Hampden Ave. ST., 13 WARD)

2-FULL NAME Thomas B. Fallon

(a) RESIDENCE No. 2602 Hampden Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Alice Hare

6 DATE OF BIRTH (month, day, and year) May 20, 1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41	1	25	

8 OCCUPATION OF DECEASED Machinist.

(a) Trade, profession or particular kind of work Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer) ------ 031

(c) Name of employer Not Employed

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Fallon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Keating

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co., Md.

14 Informant Mrs. Edith A. Fallon

(Address) 2602 Hampden Ave.

15 JUL 17 1922 ROBERT R. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 27 19 19 to July 15 19 22.

that I last saw him alive on July 10 19 22

and that death occurred, on the date stated above, at 11.15 P.M.

The CAUSE OF DEATH* was as follows:

Primary Genito urinary tuberculosis

(Duration not definitely known)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac muffrerg

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe F. Cross M. D.

July 18 22 (Address) 2438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Cem. Texas, Md	7/18/22 19

20 UNDERTAKER	ADDRESS
Henry W. Mears & Son, 805	N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. A state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

D 66031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66031

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3907 Lloyd Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Serina Cameron

(Residence in Baltimore: No. 3907 Lloyd Ave. St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. about ..... (Month) ..... (Day) 1857 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Cameron

(Address) 3907 Lloyd Ave

15- Filed JUL 17 1922 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 15 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

July 16 192 2 (Address) 220 E Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion - Frederick — DATE OF BURIAL, July 18 192 2

20-UNDERTAKER, E L Roy Shaffer — ADDRESS 1245 North Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66032

CERTIFICATE OF DEATH.

D 66032

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ISAAC KESSLER

(a) RESIDENCE. No. Macon Ga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Wolf Kessler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Chronanofsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. H. Kessler
(Address) Macon Ga

15 Filed JUL 17 1922 ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 19 22

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to July 17, 1922, that I last saw him alive on July 17, 1922, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Bile ducts

(duration) yrs. 4 (?) mos. ds.

18 Where was disease contracted if not at place of death? Macon Georgia

Did an operation precede death? Yes Date of July 15, 22.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Freeman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MACON Ga	July 17 19 22
20 UNDERTAKER	ADDRESS
Jack Lewis	439 E Balto

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66033

D 66033

CERTIFICATE OF DEATH.

129

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Evans

(a) RESIDENCE. No. 1820 E Oliver ST.. ...WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Evans

6 DATE OF BIRTH (month, day, and year) 1867 Apr 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George Wood

11 BIRTHPLACE OF FATHER (city or town) — (State or country) England

12 MAIDEN NAME OF MOTHER Cecilia Dutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

11 Informant Hospital Records (University Hosp.) (Address) Lombard and Greene Sts

15 Filed JUL 17 1922 ROBERT R. KNAUER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 7 . 19 22 to July 17 . 19 22

that I last saw her alive on July 17 . 19 22

and that death occurred, on the date stated above, at 1745 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

Myocarditis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Laboratory findings

(Signed) H. B. Jones, M. D.

(Address) Univ. City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 19 22
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66034

CERTIFICATE OF DEATH.

118-001 D 66034

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) (WARD)

2-FULL NAME Mrs. Helen Schaut.

(a) RESIDENCE No. 970 N. Chester St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Geo. A. Schaut

6 DATE OF BIRTH (month, day, and year): Aug 19th 1864

7 AGE — Years: 57. Months: 10 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jos. A. Fremmier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helen Hewsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles A. Schaut

(Address): 970 N Chester St

15 Filed JUL 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1922

17

I HEREBY CERTIFY, That I attended deceased from July 9 1922 to July 15 1922.

that I last saw her alive on July 15 1922

and that death occurred, on the date stated above, at 8 20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) 5 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary): Strangulated Vent. Hernia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 9, 22

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) S W. Rouzer, M. D.

(Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: July 17 1922

20 UNDERTAKER: Geo M. Frick & Son

ADDRESS: 811 N. Wolfe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66035

CERTIFICATE OF DEATH.

128 D 66035

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2729 E Monument ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Mitchell

(a) RESIDENCE. NO. 2729 E Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm T Mitchell

6 DATE OF BIRTH (month, day, and year) Dec 20 93

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Appel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Laura Rhaltes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edward T Appel

(Address) 2729 E Monument

15 JUL 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15-22

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922 to July 15, 1922

that I last saw h[illegible] alive on July 15, 1922

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows: Nephritis Acute Parenchymatous

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Albumen & Casts

(Signed) W Van Williams, M. D.

, 19 (Address) 601 Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Grove Cemetery	July 19 1922
20 UNDERTAKER	ADDRESS
H M Kourtom	2238 N Howard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66036

CERTIFICATE OF DEATH.

122-002

D 66036

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 6510 George St. Lowerwood Terrace ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Helen Trapnell

(a) RESIDENCE. No. 6510 George ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Trapnell

6 DATE OF BIRTH (month, day, and year) Jan. 4. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	6	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Schoenstadt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Conradt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Annie H. Faust

(Address) 6510 George St.

15 Filed JUL 18 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1922

17

I HEREBY CERTIFY, That I attended deceased from June 7th, 1922 to July 16th, 1922.

that I last saw her alive on July 15th, 1922.

and that death occurred, on the date stated above, at 3 11 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Frank E. Eldred, M. D.

July 19 1922 (Address) Spring Bank. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 19 1922
20 UNDERTAKER	ADDRESS
Wm. John H. Taylor & Son	21 W. Lanvale

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Alcoholic

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66037 X 113 D 66037

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 237 N. Pulaski ST., 18 WARD)

2-FULL NAME Maud Trower

(a) RESIDENCE No. 237 N Pulaski (Usual place of abode) ST., ... WARD ...

Length of residence in city or town where death occurred X yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 11 Months 8 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: X

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer: X

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Alfred Trower

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Bertha Roane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Father Trower (Address) 237 N. Pulaski St

15 Filed JUL 18 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 16th, 1922, that I last saw her alive on July 16, 1922, and that death occurred, on the date stated above, at 9. P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? X Date of X.

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) J. E. Edmunds, M. D.

, 19 (Address) 1002 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 18 1922

20 UNDERTAKER: Brown & Fieldsend — ADDRESS 1142 W. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66038

CERTIFICATE OF DEATH.

D 66038

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Western Maryland Station, St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Roberts

(Residence in Baltimore: No. 248 W. 18th St.) St.; yrs., 74 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Married

6-DATE OF BIRTH, ..., 1843
(Month) (Day) (Year)

7-AGE, 79 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook, waiter
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE. (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, By Roberts

11-BIRTHPLACE OF FATHER (State or Country). Lewistown, Md.

12-MAIDEN NAME OF MOTHER ×

13-BIRTHPLACE OF MOTHER (State or Country). ...

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Roberts

(Address) 248 W. 18th St.

15-

Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

JUL 18 1922 Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral apoplexy

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 17 1922. (Address) 1637 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). In the

At place of death.... yrs.... mos.... ds. State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	July 18, 1922

20-UNDERTAKER Brown & Ireland & Schroder ADDRESS 1140

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66039

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 E. Lombard St.; V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Zagodzinski

(a) RESIDENCE. No. 1839 E. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Co

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 17, 1922

7 AGE: Years | Months | Days | If LESS than 1 day, Hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER August Zagodzinski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER Helen Serba

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Buffalo N.Y.

14 Informant: Father

(Address)

15 Filed JUL 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922 to July 17, 1922 that I last saw him alive on July 17, 1922 and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 6 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Kemp Co. M. D.

7/17, 1922 (Address) 2062 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross (Leman Hill Road)	July 18 1922
20 UNDERTAKER	ADDRESS
Wendell Dysart & Son	378 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ransom M. Middleton

D 66040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66040

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. Howard A. Kelly Hospital St.; WARD)

2-FULL NAME Mr. Ransom M. Middleton.

(a) RESIDENCE. NO. 123 Wamman St., ST., WARD. Greensboro, N.C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian Gainey Middleton Clarkson.

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 36 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bank Cashier.

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Warsaw, N.C.

PARENTS

10 NAME OF FATHER: Ransom Monroe Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Duplin County, N.C.

12 MAIDEN NAME OF MOTHER: Mittie Faison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sampson County, N.C.

14 Informant: Mrs. T. B. Southall

(Address): 700 Park Ave City

15 JUL 18 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to July 18, 1922, that I last saw him alive on July 18, 1922, and that death occurred, on the date stated above, at 6 45 a.m.

The CAUSE OF DEATH* was as follows:

Caranoma of rectum.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Biopsy.

(Signed) Robt E. Fowler, M. D.

, 19 (Address) 1418 Eutaw Place, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greensboro N. C. DATE OF BURIAL: July 18 1922

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

D 66041 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 66041

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 S. Charles ST., 22 WARD)

2-FULL NAME Sarah Brodie

(a) RESIDENCE. No. 732 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah Epstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Brodie (Address) 732 S. Charles st

15 Filed JUL 18 1922 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1922, to July 17, 1922, that I last saw h e alive on July 16, 1922, and that death occurred, on the date stated above, at 2 h. m.

The CAUSE OF DEATH* was as follows:

Hypocarditis (with advancing old age)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (hot weather ?) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) Frank J. Smith, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd — DATE OF BURIAL July 18 1922

20 UNDERTAKER Max Levinson — ADDRESS 1121 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

Clark.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155-326

D 66042

1-PLACE OF DEATH

65-201

D 66042

REGISTERED NO.

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME AGNES H. CLARK

(a) RESIDENCE. No. 200 W. LAFAYETTE AVE. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 22, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
	36	10	25	

8 OCCUPATION OF DECEASED 2

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John R. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard County, Maryland

12 MAIDEN NAME OF MOTHER Susan Owings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 18 1922 19

ROBERT R. KRAUTER, Deputy Registrar Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1922, to July 17, 1922, that I last saw HER alive on July 17, 1922, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Ac. Myeloid Leukemia

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John L. Donsay, M. D.

19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loretto Cem. Elkton Md. 19

20 UNDERTAKER — ADDRESS

Grand Funeral Co.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D 66043

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brower

(a) RESIDENCE No. 1409 Dallas St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER William Brower

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records,

(Address) Municipal Hospital.

15 Filed JUL 18 1922 ROBERT R. [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 17, 1922,

that I last saw him alive on July 16, 1922

and that death occurred, on the date stated above, at 8:35 A.M.

The CAUSE OF DEATH* was as follows:

Atrophic Hepatic Cirrhosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Snavely M. D.

7/18/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: July 18 1922

20 UNDERTAKER: J. R. Spencer & Co. ADDRESS: 325 E. Eutaw St.

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66044

CERTIFICATE OF DEATH.

179

D 66044

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mpaity Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lee

(Residence in Baltimore: No. 706 N Carolina St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colrd

5-Single, Married, Widowed or Divorced, (Write the word.): Sgle

6-DATE OF BIRTH: Dont Know (Month) (Day) (Year)

7-AGE: 24 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Dont Know

PARENTS.

10-NAME OF FATHER, / /

11-BIRTHPLACE OF FATHER, (State or Country). / /

12-MAIDEN NAME OF MOTHER, / /

13-BIRTHPLACE OF MOTHER, (State or Country). / /

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Filed JUL 18 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) burns on body accidently recvd

(Duration) yrs. mos. ds.

(Signed) A M Schmidt M. D.
(Coroner.)

7-17 1922 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

UNIVERSITY OF MARYLAND
JUL 1 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66045

CERTIFICATE OF DEATH.

161-001 D 66045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 China St ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mason

(a) RESIDENCE. NO. 814 China ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Mason

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co Maryland

12 MAIDEN NAME OF MOTHER Lemma Parker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co Maryland

14 Informant Lemma Mason (Mother)
(Address) 814 China St.

15 Filed JUL 18 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 16, 1922

that I last saw him alive on July 16, 1922

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

717. 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS JUL 17 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5/36

19367

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 66046 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66046

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery and Childs ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Milton Graser

(a) RESIDENCE. No. 18 N. Kenwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 16, 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	3	120	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Martin Shoemaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Graser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Margaret Graser (Address) 18 N. Kenwood Ave

15 FILED JUL 18 1922 G G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to July 17, 1922, that I last saw h alive on July 16, 1922, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

C. Chronic Intestinal Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jose L Pierce Jr M. D.

, 19 (Address) 1005 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL 7/18 1922

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans

D 66047 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 66047

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 W. Saratoga St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Schapiro

(Residence in Baltimore: No. 427 W Saratoga St St.; yrs. 24 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced: (Write the word)
Male	White	Mrd

6-DATE OF BIRTH: Dont Know (Month) (Day) (Year)

7-AGE: 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Russia

PARENTS:
10-NAME OF FATHER: Solomon Shapiro
11-BIRTHPLACE OF FATHER (State or Country): Russia
12-MAIDEN NAME OF MOTHER: Rosa Bernstein
13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Perlman.

(Address) 427 W Saratoga St

15-

Filed JUL 18 1922 192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 18 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest, au~~ ~~topsy or~~ Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malignant tumor of the Heart

Dont Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) W B Gorman M. D.

(Coroner.)

July 18 1922 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	July 19 22

20-UNDERTAKER: Max Lawyer ADDRESS: E. Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—(MAT—500 M)

D 66048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66048

CERTIFICATE OF DEATH.

148

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard + Greene ST., 26 WARD)

2-FULL NAME Mrs Frances Elksnis

(a) RESIDENCE NO. cor Durley + Sipple Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 17 yrs. . . mos. . . ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anthony Elksnis

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years: 34 | Months: | Days: | If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Nokn0W

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithvania

12 MAIDEN NAME OF MOTHER: Nokn0W

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithvania

14 Informant (Address): University Hospital Records

15 JUL 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to July 17, 1922, that I last saw her alive on July 17, 1922, and that death occurred, on the date stated above, at 6 05 P m.

The CAUSE OF DEATH* was as follows:

Nephritis Toxemia of Pregnancy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 20th 1922

20 UNDERTAKER: John Grebliauckas — ADDRESS: 425 S Paca St

F.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66049

CERTIFICATE OF DEATH.

31 D 66049

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 N. Saratoga ST.; 18 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Smith

(Residence in Baltimore: No. 824 N. Saratoga St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): W

6-DATE OF BIRTH, ..., 1896
(Month) (Day) (Year)

7-AGE, 26 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER: [illegible]

11-BIRTHPLACE OF FATHER (State or Country): [illegible]

12-MAIDEN NAME OF MOTHER: [illegible]

13-BIRTHPLACE OF MOTHER (State or Country): [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Gordon

(Address) 916 Dallas

15-

Filed JUL 18 1922, 191.... RPW
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25, 1922, to July 17, 1922, that I saw h[illegible] alive on July 15, 1922, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) yrs. 1 mos. 2 ds.

(Signed) D. Frank Dott M. D.

July 17, 1922 (Address) 334 N. Bethel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rock Hall Md. DATE OF BURIAL, July 19, 1922

20-UNDERTAKER, Daniel Gordon & Co. ADDRESS [illegible]

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 66050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66050

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 Allendale St. 21 Ward) 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME March Pugh

(Residence in Baltimore: No. 212 Allendale St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	colored	Single

6-DATE OF BIRTH. March (Month) 3 (Day) 1922 (Year)

7-AGE. .....yrs. 5 mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Alex Pugh Otho

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Lycile Pugh Mary Alice Standley

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eyler

(Address) 916 Pac ave

15- Filed JUL 18 1922 192 RRH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest au(Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

.....(Duration).....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary) Heart & Kidney

.....(Duration).....yrs.....mos.....ds.

(Signed) W B Gorsuch M. D. (Coroner)

7-18 1922 (Address) 117 N Sangston

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL. July 19 192

20-UNDERTAKER. Geo Eyler & Sons ADDRESS 916 Pac ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6605I

D 6605I

CERTIFICATE OF DEATH.

46

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 N. Arlington Ave. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Reister

(Residence in Baltimore: No. 915 Arlington Ave. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 2 (Day), 1853 (Year)

7-AGE, 69 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Kept Boarders
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, J. George Reister

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Margaret Hachtel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret E. Schaefer

(Address) 915 N. Arlington Ave.

15-

Filed ....., 191.... R. R. M.

JUL 18 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1921, to July 17 1922, that I saw h Er alive on July 17 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

..... (Duration) — yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) — yrs. — mos. — ds.

(Signed) Herbert F. Steelman M. D.

July 18, 1922. (Address) 1227 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, July 19th, 1922

20-UNDERTAKER Wilbur W. Shriver

ADDRESS 1018 Edmondson Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66052

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1208 S Ellwood Av ST., 1 WARD)

2-FULL NAME Francis Roguski.

(a) RESIDENCE NO. 1208 S. Ellwood Av ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. — How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 5-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md — U S A

PARENTS

10 NAME OF FATHER Waclaw Roguski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Zofia Powiatowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Waclaw Roguski
(Address) 1208 S. Ellwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11 .1922. to July 18 .1922.

that I last saw him alive on July 18 .1922.

and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis.

(duration) yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan Friedman M. D.

, 19 (Address) 303 S Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem — DATE OF BURIAL July 19 1922

20 UNDERTAKER Stefan J Fiedkowski — ADDRESS 1000 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 18 1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro.

D 66053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66053

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Sabina L. Schmitzlein

(Residence in Baltimore: No. 1711 W Balto St St.; 5 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. July (Month) 9 (Day) 1886 (Year)

7-AGE. 36 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)... at home

9-BIRTHPLACE, (State or Country) Washington DC.

PARENTS.

10-NAME OF FATHER. Williams

11-BIRTHPLACE OF FATHER, (State or Country) Washington DC.

12-MAIDEN NAME OF MOTHER. Mary E. Quigley

13-BIRTHPLACE OF MOTHER, (State or Country) Washington DC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Schmitzlein

(Address) 1711 W Balto St

15-

Filed ..... 192.....

Registrar.

R 18 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strychnine Poisoning
Self administered
Probly Accident

(Duration)....yrs.....mos. 2 hrs

CONTRIBUTORY (Secondary)

(Duration)....yrs.....mos.....ds.

(Signed) James M. Hamilton M. D.
(Coroner.)

July 17 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 1711 W Balto St

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
CONGRESSIONAL CEM WASHINGTON	7/21 1922

20-UNDERTAKER	ADDRESS
Robert Burkam DC	CALHOUN ST HOLLINS

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66054

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Byrd St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Wm. Giles

(a) RESIDENCE. NO. 1516 Byrd St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Pipkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Louis Giles
(Address) 1516 Byrd St.

15 Filed JUL 18 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 19 22, to 7/18, 19 22,
that I last saw h[illegible] alive on 7/18, 19 22,
and that death occurred, on the date stated above, at 10.45 a. m.
The CAUSE OF DEATH* was as follows:

Cholera Infantum
Vomit

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

7/19 19 22 (Address) 1 1 Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	7/19 1922
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

(Creigler)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66055

CERTIFICATE OF DEATH.

1-001

D 66055

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2818 Fox St., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Creigler

(a) RESIDENCE NO. 2818 Fox ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: De

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Creigler

6 DATE OF BIRTH (month, day, and year): Nov. 2, 1900

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
21	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

(c) Name of employer: Dr. Geo. H. Bunting

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ella Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Samuel Baker

(Address) 2818 Fox St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922, to July 16, 1922

that I last saw her alive on July 16, 1922

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Typhoid fever ?

R.S.O.

(duration) Abt 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Acute Meningitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Exam.

Signed R. Paul Emmell, M. D.

1922 (Address) 1534 E. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 7/19 1922

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

18 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66056

CERTIFICATE OF DEATH.

102 D 66056

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Mount Hope Retreat ST.: 28 WARD

2-FULL NAME Dadie Goss

(a) RESIDENCE No. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 28-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bottle wrapper Baltimore Md 080
(b) General nature of industry, business, or establishment in which employed (or employer) Wrapping bottles
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jas P. Goss
11 BIRTHPLACE OF FATHER (city or town) Charleston
(State or country) S. C.
12 MAIDEN NAME OF MOTHER Mary A. Luke
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Record of Mt Hope Retreat
(Address) Mt Hope Retreat.

15 Filed JUL 18 1922, 19 Registrar RPM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 13th, 1911, to July 18th, 1922, that I last saw her alive on July 17th, 1922, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Pleurisy — Weak Exhaustion

x

abt

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Praecox — Paranoid type (duration) 11 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Lammey, M. D.

July 18th, 1922 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	7/20 1922
20 UNDERTAKER William Cook C	ADDRESS 502 E North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

× Not Tuberculous

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66057

CERTIFICATE OF DEATH.

D 66057

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 Harford Ave St.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Johnson

(Residence in Baltimore: No. 2100 Harford Ave St.; 2 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct. (Month) 4 (Day), 1874 (Year)

7-AGE, 47 yrs. 9 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John McFaul

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Johnson

(Address) 2100 Harford Ave

15-

Filed ....., 191.....

Registrar.

JUL 18 1922 ORR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1922, to July 17, 1922, that I saw h er alive on July 15, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene L. Pessano M. D.

July 18, 1922 (Address) Glen Hills

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Parkwood	July 20 1922
20-UNDERTAKER	ADDRESS
E. Le Roy Stiffler	1255 North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66058

113

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1634 N Durham ST.; 8 WARD)

2-FULL NAME Christian Ogle

(a) RESIDENCE. No. 1634 N Durham ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 15 1922

7 AGE — Years: — Months: 5 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Ogle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lena Wild

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John Ogle
(Address): 1634 N Durham st

15 JUL 18 1922, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 17, 1922, that I last saw him alive on July 16, 1922, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H O Herzog M. D.

7/17, 1922 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: July 19 1922

20 UNDERTAKER: Henry Lutz — ADDRESS: 1203 N. Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66959

CERTIFICATE OF DEATH.

4 X 109-B 66059

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; ..... WARD)

2-FULL NAME Le Glyn Saulter

(a) RESIDENCE. NO. 1042 3 - 109th St - Longf St. Island WARD. 4 4.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 8, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Repairer 015

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenters

(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) New York -

PARENTS

10 NAME OF FATHER Otis Saulter

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Lavagne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

11 Informant (Address) Wm Saulter - (Brother)

15 Filed ..... 19 ..... Registrar

JUL 18 1922 C. R. M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 8 1922 to July 17 1922

that I last saw h alive on July 14 1922,

and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Retro-pharyngeal abscess

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis? Clinical findings & Autopsy

(Signed) F. H. Bryenbock M. D.

July 19 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnet Brae — DATE OF BURIAL July 19, 22

20 UNDERTAKER Harry H. Weitzel — ADDRESS 1531 W. Lombard

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66060

CERTIFICATE OF DEATH.

113 D 66060
Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 So. Decker Ave St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt L. Bowers Jr

(Residence in Baltimore: No. 701 So. Decker Ave St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. July (Month) 5th (Day) 1922 (Year)

7-AGE. ... yrs. ... mos. 13 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): Job

9-BIRTHPLACE. (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER. Robt L. Bowers Sr

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Lottie E. Carroll

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt L. Bowers Sr

(Address) 701 So. Decker Ave

15- Filed JUL 19 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Indigestion

17 hours (Duration) ... yrs.

CONTRIBUTORY (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos J. Gardner M. D. (Coroner.)

July 18 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. July 19 1922

20-UNDERTAKER George J. Smith ADDRESS 25 W. Lexington St

D 66061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. (Negro) 27

D 66061

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 Arlington Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Laurence R. Thomas

(Residence in Baltimore: No. 1209 Arlington Ave St.; yrs. Life mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Married

6-DATE OF BIRTH. Apr (Month) 14 (Day) 1894 (Year)

7-AGE. 28 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Porter
(b) General nature of industry, business, or establishment in which employed (or employer). 2 yrs 000

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John W. Thomas

11-BIRTHPLACE OF FATHER, (State or Country). Talbot Co Md

12-MAIDEN NAME OF MOTHER. Laura Johns

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Thomas

(Address) 1209 Arlington Ave

15-

Filed JUL 19 1922 ROBERT R. KNAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secoudary) Tuberculosis

(Duration) 2½ yrs. mos. ds.

(Signed) Jos. Paul M. D.
(Coroner)

7-19, 1922 (Address) 5.0.5 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn Cem — DATE OF BURIAL. July 19 22

20-UNDERTAKER. Samuel Kennedy — ADDRESS. 1628 E Pratt St

Spec. 1-10-21 M&T 1500 Blks.

D 66062

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D 66062

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Vincents Infant Asy

CITY OF BALTIMORE: (No. 1401 - division ST., 14 WARD)

2-FULL NAME Doris O'meara

(a) RESIDENCE NO. 1401 - division ST. 14 WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 15th 1920

7 AGE: Years 1 Months 7 Days If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Spencer Seward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Marvel O'meara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant St Vincent Inf. Asylum
(Address) 1401 Division St.

15 Filed JUL 19 1922 Registrar ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1922, to July 17th, 1922, that I last saw h[illegible] alive on July 17th, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Debilitation

Acute (duration) 0 yrs. 0 mos 10 ds.

CONTRIBUTORY (Secondary) ET — (duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of .....

Was there an autopsy? — No

What test confirmed diagnosis? .....

(Signed) Frank J Flannery M. D.

July 15th 1922 (Address) 1401 Hoe Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL July 19 1922

20 UNDERTAKER: Martin Luskey & Son — ADDRESS 1837 W North ave

Spec. 1-10-21 M&T 1500 Bks.

D 66063

HEALTH DEPARTMENT—CITY OF BALTIMORE

V-001

161 D 66063

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Womans Hospt

CITY OF BALTIMORE: (No. Lafayette Ave & John St. 14 WARD)

2-FULL NAME Baby Sorrell

(a) RESIDENCE NO. Womans Hospital ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs or 40 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Leo B. Sorrell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary J. Giles

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant Leo Sorrell
(Address) 1412 Eutaw Ave

15 Filed JUL 19 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 17, 1922, that I last saw h.. alive on July 17, 1922, and that death occurred, on the date stated above, at 0 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis -

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Infant.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. H. Carlson M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL July 17 1922

20 UNDERTAKER Martin Fahey & Sons.

ADDRESS 1827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66064

CERTIFICATE OF DEATH.

113 D 66064

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 S. Paca ST.: 22 WARD)

2-FULL NAME Bertha Marie Tucker

(a) RESIDENCE. No. 535 S Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 29. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) 264 St Peter
(State or country)

PARENTS

10 NAME OF FATHER Julius D Tucker

11 BIRTHPLACE OF FATHER (city or town) Hollywood
(State or country) St Marys Co Md.

12 MAIDEN NAME OF MOTHER Catherine Ferguson

13 BIRTHPLACE OF MOTHER (city or town) Hollywood
(State or country) St Marys Co Md.

14 Informant Father
(Address) 535 S Paca St Balto Md.

15 Filed JUL 18 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14. 1922. to July 17. 1922.
that I last saw her alive on July 17. 1922.
and that death occurred, on the date stated above, at 8.50 P m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M Delevett, M. D.

July 17 1922 (Address) 621 Columbia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters. DATE OF BURIAL July 19 1922

20 UNDERTAKER Bernard A Funk ADDRESS 1175 Columbia Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

66065 D 66065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Elmo

(a) RESIDENCE NO. 416 Allen Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Jos. Caparelli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant (Address) Mercy Hosp

15 Filed JUL 19 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922 to July 19, 1922

that I last saw her alive on July 19, 1922

and that death occurred, on the date stated above, at 7^00 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Regurgitation

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Signs

(Signed) D. J. Esposito, M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cemetery DATE OF BURIAL 7/21/1922

20 UNDERTAKER A. S. Marshall 3539 ADDRESS Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66066

D 66066

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1122 Hollins St. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Joseph Snoops

(a) RESIDENCE NO. 1122 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Snoops

6 DATE OF BIRTH (month, day, and year) Sept. 25th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 04J

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Snoops

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant George J. Snoops

(Address) 1122 Hollins St.

15 Filed JUL 19 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/15 —, 192—, to 7/17 —, 19—,

that I last saw h— alive on 7/17 —, 19—

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral Hemorrhage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

7/18, 19 22 Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cem

DATE OF BURIAL July 20 1922

20 UNDERTAKER Joseph B. Cork

ADDRESS 1003 N. Gay St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66067

D 66067

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 N. Montford Ave. ST., 8 WARD)

2-FULL NAME Mary E. Schaech

(a) RESIDENCE NO. 1404 N. Montford Ave ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis J. Schaech.

6 DATE OF BIRTH (month, day, and year) Feb. 3- 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	5.	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John D. Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary A. Cabot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Caroline E. Lowe (Address) 1707 N. Montford Ave

15 Filed JUL 19 1922 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to July 18, 1922

that I last saw h[illegible] alive on July 16, 1922

and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Pylorus)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

7/19, 1922 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cath. Cemetery

DATE OF BURIAL July 21 1922

20 UNDERTAKER [illegible] & Zeib

ADDRESS 403 S. Mo[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 66068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66068

47

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Callow Ave. St. 13 WARD)

2-FULL NAME Minnie Frankel

(a) RESIDENCE NO. 2116 Callow Ave. ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby. 22 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Frankel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Yette Block

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. Lydia Frankel

(Address) 2116 Callow Ave.

15 Filed JUL 19 1922 GL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/ 1922.

17

I HEREBY CERTIFY, That I attended deceased from Jany. , 1919 , to July 17 , 1922

that I last saw her alive on July 17 , 1922

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast (Primary)

Chronic Interstitial Nephritis

Arteriosclerosis

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of many years ago

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical symptoms and Roentgen ray

(Signed) Howard C. Silver M. D.

, 19 (Address) 3706 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem. DATE OF BURIAL 7/20 1922

20 UNDERTAKER David Sondheim ADDRESS 115-201 W. Mt. Royal Ave.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66069

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66069

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Riviera Apts ST. 13 WARD)

2-FULL NAME Irving Lionel Lehman

(a) RESIDENCE NO. Riviera Apts ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruth M. Lehman

6 DATE OF BIRTH (month, day, and year): Aug. 29 1900

7 AGE — Years: 21 — Months: 10 — Days: 20 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work: Assistant Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Steamship Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Louisville, Kentucky

PARENTS

10 NAME OF FATHER: Clarence M. Lehman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Bertha Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

14 Informant (Address): Mr. Clarence M. Lehman, Riviera Apts.

15 JUL 19 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/19/1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1921, to July 19, 1922.

that I last saw h alive on July 19, 1922,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

mitral stenosis.

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) rheumatic fever (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Whitehorne, M. D.

, 19 (Address) 1810 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Hebrew Cem. DATE OF BURIAL: 7/21/1922

20 UNDERTAKER: David Sondheim ADDRESS: 118 W. Mt.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 16 66070

1-PLACE OF DEATH

REGISTERED NO. 66070

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Thompson

(a) RESIDENCE. No. 1021 Bush St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred . yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 13-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Kimball

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 19 1922, 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12th, 1922, to July 17th, 1922; that I last saw h.. alive on July 17th, 1922; and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Dysentery,

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool culture

(Signed) T B Gay, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. DATE OF BURIAL July 19 1922

20 UNDERTAKER Margaret G. Flynn ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Shiga type.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66071

D 66071

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Shot at Belle Grove Inn, A. A. Co. Md. 18 19

City of BALTIMORE: (No pronounced dead at South Baltimore Ward)
General Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Furcello.

(Residence in Baltimore: No. 848 W. Fayette St. St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. (Month) (Day) 1..... (Year)

7-AGE. 26 yrs. ---- mos. ---- ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE. (State or Country). New York.

PARENTS.

10-NAME OF FATHER. Peter Furcello.

11-BIRTHPLACE OF FATHER, (State or Country). Italy.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Arthur.

(Address) 100 Mt. Royal Ave.

15- Filed JUL 19 1922 192 G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 16th. 1922. (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inqy. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage, due to a bistol shot wound in the Abdomen. Homicide.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Bernardt M. D. (Coroner)

July 13 1922 (Address) 10 17 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Belle Grove Inn, A. A. Co. Md. 7/16/22.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New York	July 19 1922
20-UNDERTAKER. Margaret M. Flynn	ADDRESS 1700 Eutaw Pl.

Spec.—1-10-21—M&T—1500 Bks.

D 66972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 D 66072

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

2-FULL NAME James Richardson

(a) RESIDENCE NO. 4085 St Paul ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66. yr.	—	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Thomas Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Annie Matheson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mercy Hospital Record (Address)

15 Filed JUL 19 1922 H. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922. to July 18, 1922.

that I last saw h[illegible] alive on July 18, 1922.

and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH was as follows:

Carcinoma of Oesophagus

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 20'22

Was there an autopsy? No.

What test confirmed diagnosis? Operation & oesophagoscopy

(Signed) D. J. Kresnagan M. D.

, 19 (Address) Mercy Hosp.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 7/20 1922

20 UNDERTAKER Henry W. Means & Son — ADDRESS 8054 Cedar Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66073

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66073

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1355 N Eutaw St., St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celestine Reed

(Residence in Baltimore: No. 1355 N Eutaw St. St.; 3 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Black | 5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: about (Month) (Day) 1919 (Year)

7-AGE: 3 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS:
10-NAME OF FATHER,
11-BIRTHPLACE OF FATHER, (State or Country),
12-MAIDEN NAME OF MOTHER,
13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Reed

(Address) 1355 N Eutaw St

15-

Filed JUL 19 1922

ROBERT R. KRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) none existing

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

July 19 1922 (Address) 250 Fallsway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn | DATE OF BURIAL: July 19 1922

20-UNDERTAKER: James H. Dennis | ADDRESS: 303 Cherokee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66074

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66074

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 President ST., 3 WARD)

2-FULL NAME John Morisi

(a) RESIDENCE NO. 318 President ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Morisi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Morisi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Morisi, Morris

(Address) 315 Prospect

15 JUL 19 1922 Filed, 19

ROBERT R. KRAUSE

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to July 17, 1922, that I last saw h— alive on July 17, 1922, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A. F. Ries, M. D.

July 18 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent

DATE OF BURIAL July 20 1922

20 UNDERTAKER Wendell Dysel Co

ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66075

90 D 66075

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. 902 Harford Ave. ST. 10 WARD)

2-FULL NAME George Fuller

(a) RESIDENCE NO. 902 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: 73 (Years / Months / Days) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Nixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma Taylor

(Address) 2018 E North Ave

15 Filed JUL 19 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 22

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to July 19, 1922, that I last saw h[illegible] alive on July 18, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Fitch M. D.

July 19 1922 (Address) 4364 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem. DATE OF BURIAL: July 21 1922

20 UNDERTAKER: Leo. G. Cook. ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 66076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66076

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 Ridgely ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry G Porter

(a) RESIDENCE NO. 1037 Ridgely ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Violet C. Porter

6 DATE OF BIRTH (month, day, and year): July 19 1877

7 AGE — Years: 44 — Months: 11 — Days: 30 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Switchman

(b) General nature of industry, business, or establishment in which employed (or employer): 073

(c) Name of employer: B&O RR Balto

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Chas. Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Elizabeth Bagless

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant (Address): Violet C. Porter (wife) 1037 Ridgely st

15 Filed 19 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922 to July 18, 1922 that I last saw h[illegible] alive on July 17, 1922 and that death occurred, on the date stated above, at 7 11 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Britt, M. D.

19 27 Address 602 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park cemetery — DATE OF BURIAL: July 20 1922

20 UNDERTAKER: James Dignan & Son — ADDRESS: 1010 S. Paca st

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66077

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 W. Montgomery St. St., 22 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Allen.(C).

(Residence in Baltimore: No. 640 W. Montgomery St. St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH. Do not know. ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
70 yrs. --- mos. --- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. fpd
(b) General nature of industry, bnsiness, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella Jones.(C).

(Address) 137 W. York Street.

15-

Filed JL 19 1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. E. Reinhardt M. D. (Coroner.)

July 17, 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
PUBLIC CEMETERY.	....., 19....
20-UNDERTAKER.	ADDRESS JUL 1 1922

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THE MORGAN.

Spec.—3-10-21—M&T—1500 Bks.

D 66078

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 66078

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST. 18 WARD)

2-FULL NAME Alma F Letcher

(a) RESIDENCE NO. 839 Boyd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Black | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE — Years: 38 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Phil. Jeffbrist

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Victoria Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant ..... (Address) .....

15 Filed ..... 19 ..... Burial Permit Clerk. Registrar

UL 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1922, to July 15, 1922, that I last saw her alive on July 15, 1922, and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix of uterus.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) J Richardson Joynes M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

UNIVERSITY OF MARYLAND

JUL 19 1922

Spec.—5-19-13—M. & T.—500 Bks.

D 66079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66079

REGISTERED NO. C 160

1-PLACE OF DEATH 625 N Caroline St

CITY OF BALTIMORE: (No. 625 N. Caroline St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grady Jr McCrider

(Residence in Baltimore: No. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 30 (Day), 1922 (Year)

7-AGE, — yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Presbyterian Memorial Hospital Balto

PARENTS.

10-NAME OF FATHER, Grady McCrider

11-BIRTHPLACE OF FATHER (State or Country) Anderson S.C.

12-MAIDEN NAME OF MOTHER Bertha Smith

13-BIRTHPLACE OF MOTHER (State or Country) Belmont North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. B. Kahn M.D.

(Address) 610 N. Eutaw St.

15- Dec'd Robert Harrison, 191...

Registrar.

JUL 19 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 9 1922, to July 19 1922, that I saw him alive on during and called, and that death occurred, on the date stated above, at 9:21 m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis and acute pneumonia

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Tonsilitis

(Duration) yrs. mos. ds.

(Signed) A. B. Kahn M. D.

191... (Address) 610 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS JUL 19 1922

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D 66080 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66080

CERTIFICATE OF DEATH. 121

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Mullion

(Residence in Baltimore: No. Mercy Hospital St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1842 (Year)

7-AGE: 80 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (4)

9-BIRTHPLACE (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Patrick Mullon

11-BIRTHPLACE OF FATHER. (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER. (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address) Mercy Hospital

15- Robert J. Garrison, Registrar.

Filed ..... 1922 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 18 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Deputy (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Knife Wound

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) E. C. Blades M. D.

July 19 1922 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem DATE OF BURIAL: 7/20 1922

20-UNDERTAKER: Forget & Farey ADDRESS: Fulton & Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66081

D 66081

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery and Childs Hosp. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dallas Mimms.

(a) RESIDENCE. No. Nursery and Childs Hosp. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Mimms

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Dorothy Whitford.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Winsor Md.

14 Informant Miss George A. Sutton
(Address) N. W. Hospital.

15 [illegible] Robert P. Harrison, . 19

Registrar

Burial Permit Clerk.

UL 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from . 19 , to . 19 .

that I last saw him alive on July 18 . 22 .

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal Indigestion

(duration) 0 yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. F. Harvey, Jr. M. D.

. 19 (Address) 700 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 20 22
20 UNDERTAKER	ADDRESS
George D. Smith	1000 W. [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66082

CERTIFICATE OF DEATH.

D 66082

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 Brune st ST., 17 WARD)

2-FULL NAME Rose. E. McQueen

(a) RESIDENCE NO. 724 Brune st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James McQueen

6 DATE OF BIRTH (month, day, and year): Aug 25 1887

7 AGE — Years: 34 — Months: 11 — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Davis W. Va

PARENTS

10 NAME OF FATHER: Gilbert Warnick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cant Know

14 Informant (Address): Miss Elizabeth Warnick 724 J Brune st

15 Filed ..... 19 ..... Registrar

Robert P. Carrison,

19 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922, to July 19, 1922, that I last saw her alive on July 18, 1922 and that death occurred, on the date stated above, at 12 05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gen. Anaemia

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. W. Hemmeter M. D.

19 (Address) 800 Harlem Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: July 21 1922

20 UNDERTAKER: Jos Joesdens Son — ADDRESS: 217 S. Pac

Spec.—1-10-21—M&T—1500 Bks.

D 66083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66083

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 Essex ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Tymoszewska

(a) RESIDENCE NO. 2325 Essex ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Anthony Tymoszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Felixa Otrowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Felixa Tymoszewska
(Address) 2325 Essex

15 Filed , 19 Registrar

19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1922, to July 18, 1922, that I last saw h[illegible] alive on July 18, 1922, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) Bet. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

What test confirmed diagnosis? as there an autopsy? no

(Signed) Frank Sawyer Jr M. D.

7/19, 1922 (Address) 2431 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL July 20 1922

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank 17

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66084

CERTIFICATE OF DEATH.

31 D 66084

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Aliceanna ST., 3 WARD)

2-FULL NAME Anna Luczykowski

(a) RESIDENCE NO. 1516 Aliceanna ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	10	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wicenty Luczykowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lucya Paszkiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Wicenty Luczykowski 1516 Aliceanna

15 Filed ..... 19 .. Registrar

Robert F. Garrison, Burial Permit Clerk.

[19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2 , 1922, to July 19 , 1922, that I last saw h... alive on July 19 , 1922, and that death occurred, on the date stated above, at 1300 m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis

(duration) yrs. ca 2 months

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Tamplotski M. D.

7/19, 1922 (Address) 2431 Fleet

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL July 21 1922

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 66085

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66085

CERTIFICATE OF DEATH.

4 X 44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Allen

(a) RESIDENCE. No. Brunswick Md ST., WARD. Brunswick Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Etta Allen

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draymaw

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital Record. (Address)

15 Filed . 19 Registrar

JUL 19 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19 1922. to July 19 .1922

that I last saw h.m alive on July 19 .1922

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the oesophagus + clinical Adenitis

(duration) yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 20 1922

Was there an autopsy? no

What test confirmed diagnosis? Microscopic sections

(Signed) H. B. Brumback, M. D.

July 19 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brunswick Md. DATE OF BURIAL 7-19 1922

20 UNDERTAKER E & B Harle ADDRESS 115 E Wash St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-61 D 66086

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL St.: 5 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fowlks.

(a) RESIDENCE. No. 318 N. Eden St. City St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE~~ of Mary Fowlks Mother

6 DATE OF BIRTH (month, day, and year) April 23, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER William Carter.

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER Mary Fowlks

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed JUL 20 1922 ROBERT A. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922, to July 17, 1922, that I last saw h[illegible] alive on July 17, 1922, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (primary)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horace G. Stuart, M. D.

7/18, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	July 20 1922

20 UNDERTAKER John W Henderson ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66087

CERTIFICATE OF DEATH.

128 D 66087

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 811 Mc Donough St.; 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Rebecca Webb

(a) RESIDENCE. No. 811 Mc Donough St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 2, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lillian Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lillian Webb (Address) 811 Mc Donough St.

15 Filed JUL 26 1922 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to July 18, 1922.

that I last saw her alive on July 17, 1922.

and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

I did not see the case in the beginning therefore cannot State the primary cause.

(duration) — yrs. 3 mos. 21 ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) — yrs. 1 mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Peterman, M. D.

, 19 (Address) 517 Hamilton Terr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem	July 21 1922

20 UNDERTAKER David Caplan Co. ADDRESS 616

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Measles

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. does not think child had tuberculosis, ~~and~~ cough

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66088

CERTIFICATE OF DEATH.

113

D 66088

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 Carroll St. Brooklyn (WARD)

2-FULL NAME Albert Eugene Offer

(a) RESIDENCE. No. 102 Carroll St. Brooklyn

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 1922

7 AGE — Years: — Months: 6 Days: 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Brooklyn, Md

PARENTS

10 NAME OF FATHER Roland Offer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn Md

12 MAIDEN NAME OF MOTHER Laura Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn Md

14 Informant Herbert Green

(Address) Brooklyn, Md.

15 Filed JUL 20 1922 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 22

17 I HEREBY CERTIFY, That I attended deceased from July 14th 1922 to July 19th 1922

that I last saw him alive on July 17th 1922

and that death occurred, on the date stated above, at 3.20 A.M.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

July 19 1922 (Signed) Thos. P. Horton M. D.

(Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Furnace Branch

DATE OF BURIAL: July 20 1922

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66089

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

D 66089

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 52 Raspe Ave (Raspeberg) ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa F. Briggeman

(a) RESIDENCE NO. 52 Raspe Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Chas. H. Briggeman

6 DATE OF BIRTH (month, day, and year): Dec 10-60

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edwin C. Briggeman
(Address) 52 Raspe Ave

15 Filed JUL 20 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to July 18, 1922, that I last saw her alive on July 15, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy, Cerebral Hemorrhage. R. Side

Chronic Interstitial Nephritis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Albert W Webster, M. D.

, 19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL 7/21 1922

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Aliceanna

N. B. WRITE PLAINLY, WITH CARBON INK—THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66090

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH (Laynville)

CITY OF BALTIMORE: (No. 7 Rosekamp Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria A. Vincent

(a) RESIDENCE NO. 7 Rosekamp Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E. Vincent

6 DATE OF BIRTH (month, day, and year): July 22 - 49

7 AGE: Years 72 Months 11 Days 26 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md Chestertown

PARENTS

10 NAME OF FATHER: Michael Gleem

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Maittia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Bert Hall

(Address): 7 Rosekamp ave

15 Filed JUL 20 1922 RG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 18, 1922

that I last saw him alive on July 18, 1922

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

* Endocarditis & Phlebitis of left Femoral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostate Nodules

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Following

(Signed) Clara Smith M. D.

July 19 1922 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 7/21 1922

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans

A PERMANENT RECORD, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Sows. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66091

CERTIFICATE OF DEATH.

D 66091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Wiley

(a) RESIDENCE. (No.) St. Vincent's asylum (St.) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 27-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) annapolis md

PARENTS

10 NAME OF FATHER Harry Wiley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Clara Shay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant (Address) Harry Wiley 3346 East ave.

15 Filed JUL 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to July 19, 1922

that I last saw her alive on July 19, 1922

and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) 0 yrs. 0 mos. 20 ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) 0 yrs. 0 mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B Macgowan, M. D.

7/19/22 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks bmet	7/20 1922
20 UNDERTAKER J J Moran	ADDRESS 300 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66092

CERTIFICATE OF DEATH.

155 D 66092

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. N Broadway ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hobbs

(a) RESIDENCE NO. 1529 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-24-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Hobbs

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Minnie C. Hobbs

(Address) 1529 W. Fayette

15 Filed JUL 20 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18 1922

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to July 18, 1922,

that I last saw h IN alive on July 15, 1922,

and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

Bilateral Sinus Mastoiditis

(duration) yrs. mos 3 5 ds.

CONTRIBUTORY (Secondary) Meningitis (Sinus) & [Pneumonia] (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? (Open)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Operation + Spinal Puncture

(Signed) Hugh C. Rice, M. D.

, 19 (Address) Church Home & Infirm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 7/21 19 22

20 UNDERTAKER William Cook — ADDRESS 502 E Monk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Scarlet Fever

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66093

CERTIFICATE OF DEATH.

49 D 66093

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospl St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas E. Crow.

(a) RESIDENCE No. 2190 Mount St St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Crow

6 DATE OF BIRTH (month, day, and year) July 17 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Crow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha Beasley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Self Md Gen Hospital
(Address)

15 Filed JUL 20 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/22 19

17

I HEREBY CERTIFY, That I attended deceased from 5/6/22 19 , to 7/18/22 19 ,

that I last saw h him alive on 7/18/22 , 19 ,

and that death occurred, on the date stated above, at 9.53 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Sarcoma
Johns Hopkins
bones.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malignant Kidney

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6/8/22

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) J. A. Tompkins, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/21 1922

20 UNDERTAKER William Corf

ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66094

CERTIFICATE OF DEATH.

D 66094

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp, (ST.) 9 (WARD)

2-FULL NAME Augusta Balls.

(a) RESIDENCE NO. 607 Cator Ave, (ST.) (WARD)
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barnabus Balls

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Wm. Sanfot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Violet I Linder
(Address) 607 Cator Ave

15 Filed JUL 20 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 18 1922.

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to July 18, 1922.

that I last saw her alive on July 18, 1922.

and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Immediate Cause Pulmonary edema - Secondary Chronic nephritis

(duration) 7 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home,

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dr. J. A. Shennick, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Mount

DATE OF BURIAL July 21 1922

20 UNDERTAKER H. C. Medefield

ADDRESS W. Fayette St

A. B. ATTENDING PHYSICIAN—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66095

HEALTH DEPARTMENT—CITY OF BALTIMORE

199 D 66095

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Giles

(Residence in Baltimore: No. 1527 McCulloh St. 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

6-DATE OF BIRTH. (Month) (Day) 1892 (Year)

7-AGE. 30 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION. (a) Trade, profession, or particular kind of work: at Home (b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country) Maryland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Walker

(Address) 1527 McCulloh St

15- Filed JUL 20 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 18 (Day) 22 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, an (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) Left Hemiplegia yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. 2 ds.

(Signed) C. C. Cadwalader M. D.

July 20 1922 (Address) 1436 Bolton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn DATE OF BURIAL. July 20, 1922

20-UNDERTAKER. John H. Toadvine ADDRESS 142 Mitchell St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66096

CERTIFICATE OF DEATH.

57 D 66096

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 754 W. Mulberry ST., 17 WARD)

2-FULL NAME John Hawkins

(a) RESIDENCE NO. 754 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe maker

(b) General nature of industry, business, or establishment in which employed (or employer) 088

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Matilda Floyd

(Address) 754 W Mulberry St

15 Filed JUL 20 1922 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15 1922 to July 1922

that I last saw him alive on July 15 1922

and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Toxemia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

(duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ap Physical & Chemical

(Signed) Geo. H. Fowler M. D.

(Address) 712 S. Chapel St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn, Cem. DATE OF BURIAL July 1922

20 UNDERTAKER John H. Toadvine ADDRESS 442 Wilkens St

N. B.—WHITE CARD, WITH CRIMSON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66097 D 66097

CERTIFICATE OF DEATH.

122-012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5600 Reisterstown Rd St.; 27 WARD) 1

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Elizabeth Watkins

(Residence in Baltimore: No. 5600 Reisterstown Rd St.; 15 yrs yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Nov unknown, 1849 (Month) (Day) (Year)

7-AGE, 72 yrs. 7 mos. unknown ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Diehl

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry H. Diehl

(Address) 5600 Reisterstown Road

15-

Filed....., 191.. ROBERT R. KRAUTER, Registrar.

JUL 20 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 1922, to July 19 1922, that I saw her alive on July 10 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

1 Chronic Ulcer

2 Chronic Mitral endocarditis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) — yrs. 6 mos. — ds.

(Signed) C. B. Evans M. D.

July 19, 1922. (Address) 5214 Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, July 21, 1922

20-UNDERTAKER J. F. Eckis

ADDRESS Reisterstown

mg

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 66098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66098

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 S. Bond. ST., 3 WARD)

2-FULL NAME Paul. Janicki

(a) RESIDENCE NO. 924 S. Bond. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Janicki

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 56 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Kazmirz Janicki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Janicki

(Address) 924 Bond St

15 Filed JUL 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 22

17 I HEREBY CERTIFY, That I attended deceased from July 16 .22 to July 18 .1922.

that I last saw h— alive on July 11 .1922.

and that death occurred, on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Robert Insley M. D.

7/19, 19 (Address) 2385 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 7/21 1922

20 UNDERTAKER: Wm Jankowski

ADDRESS: 116 Fawkway Ave.

A. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66099 D 66099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE, (No.) 2007 Ramsay St., 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma E Arnold

(a) RESIDENCE NO. 2205 Booth St., 20th WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 31 1919

7 AGE — Years: 2 — Months: 6 — Days: 19 — If LESS than 1 day, hrs or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward C Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Alberta Trott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Edward C Arnold
(Address) 2205 Booth St

15 Filed July 20, 1922 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922 to July 19, 1922.

that I last saw him alive on July 15, 1922

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): Tonsilitis & Influenza.

(duration) yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Jos H Zerfer M. D.

(Address) 1112 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: July 21 1922

20 UNDERTAKER: F B Hayward 2256 — ADDRESS: Eutaw

N. B.—WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20 1922

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66100

D 66100

CERTIFICATE OF DEATH.

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST., 4 WARD)

2-FULL NAME Joseph Sidelnic

(a) RESIDENCE NO. 3378 Gay ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9 mos.	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0 0 1

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Mary Land
(State or country)

PARENTS

10 NAME OF FATHER Frank Sibertinis

11 BIRTHPLACE OF FATHER (city or town) Italy.
(State or country)

12 MAIDEN NAME OF MOTHER Anne Illeo

13 BIRTHPLACE OF MOTHER (city or town) Italy.
(State or country)

14 Informant Frank Sibertinis
(Address) 3378 Gay St.

15 Filed ....., 19 ..... Registrar

Robert F. Hartman,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 19 1922

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1922, to July 19, 1922, that I last saw him alive on July 19, 1922, and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Measles.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneu.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No Symptoms Signs

What test confirmed diagnosis?

(Signed) J. A. Scanagatta M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer. DATE OF BURIAL: 7/20 1922

20 UNDERTAKER Geo J Ruth. ADDRESS 1730 Hanover

L 20 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 66101

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Gollery

(a) RESIDENCE. No. 825 N. Gilmor st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

009

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Gollery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Dora Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed , 19 Registrar

Robert P. Harrison,

Burial Permit Clerk.

20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1921, to July 20, 1922, that I last saw him alive on July 20, 1922, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical, sputum, X-ray

(Signed) Francis L. Daley M. D.

7-20-22 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 22 1922
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66102

CERTIFICATE OF DEATH.

58,001 D 66102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Fallon

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed ..., 19.. Registrar

L 20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from January 21 1914 to July 19 1922.

that I last saw h alive on July 18 1922

and that death occurred, on the date stated above, at 9:40 A.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

7/19/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL July 21 1922

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe #994

IMPORTANT! This certificate must be filled in with UNFADING INK and typewritten or written with pen and ink. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Vincent Brown)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66103

D 66103

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4 n Spring St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Brown

(a) RESIDENCE. No. 4 n Spring St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Gertrude Brown

6 DATE OF BIRTH (month, day, and year): Dont know 1884

7 AGE: Years 38; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer): 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Mary's Co Md

PARENTS

10 NAME OF FATHER: Vincent Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co. Md.

12 MAIDEN NAME OF MOTHER: Amelia Garner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co Md

14 Informant: Gertrude Brown

(Address): # 4 n. Spring st

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to July 19, 1922, that I last saw h... alive on July 19, 1922, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Probably Alcoholism

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Wachter, M. D.

, 19... (Address) 1 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: 7/21 1922

20 UNDERTAKER: Jas. M. Skinner

ADDRESS: 1625 E. Broadway st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 21 1922

D 66104 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66104 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 South Register St. W Ward)

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME... William Hawkins

(Residence in Baltimore: No. 30 South Register St., 14 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Apr 12th (Month) (Day) 1888 (Year)

7-AGE. 34 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer). Ship

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hawkins

(Address) 30 So. Register St

15-

Filed ..... 192.. Robert P. Harrison, Registrar.

8-2 1922 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19th (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis *

(Duration) 4 yrs. 3 mos. 4 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos B. Horton M. D. (Coroner.)

July 19th 1922 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Asbury Cem. DATE OF BURIAL. 7/22 1922

20-UNDERTAKER. Jas. M. Skinner ADDRESS 1625 E. Lond st

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Reported as tuberculosis from Thurs
Dispensary Registered office of L.B. in
Nurses Division

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66105

D 66105

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No Nursery and Childs Hosp. ST.: 16 WARD)

2-FULL NAME Mary Elizabeth Kainary (Jane O'Brien)

(a) RESIDENCE. NO. 1153 North Fulton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *******

6 DATE OF BIRTH (month, day, and year) Oct. 1, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry business, or establishment in which employed (or employer): *******

(c) Name of employer: *******

000

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER William Kainary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER Marie Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address) Maria Zimmerman 1153 N. Fulton Ave

JUL 20 1922 , 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922 to July 20, 1922.

that I last saw her alive on July 20, 1922.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 0 yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) 0 yrs. 0 mos. 12 hrs ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Mac J. Gamble, M. D.

, 19 (Address) 709 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 21 1922
20 UNDERTAKER	ADDRESS
George J. Smith	Ft. Eutaw &

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 66106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 66106

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) York Road ave Ever 37th ST. (WARD)

2-FULL NAME Ellen R. Buttner

(a) RESIDENCE No. York Road ave Evergreen ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Buttner

6 DATE OF BIRTH (month, day, and year) June 8 - 48

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Louis Stanzy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? Baldwin

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

14 Informant Rev H. B. Parsons
(Address) 1025 W Lanvale

Filed 7-20 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5 1922, to July 19, 1922, that I last saw h alive on July 19, 1922, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Gastritis chronic.

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? non.

(Signed) H. Hamill Smith, M. D.

(Address) 11 N Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL 7/22 1922

20 UNDERTAKER Williams Cook ADDRESS 502 E North

Memorial Park Cemetery

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 66107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66107

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Guilford ave ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred E Cruse

(a) RESIDENCE NO. 1602 Guilford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Charles H Cruse

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Elva D Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Charles H Cruse
(Address) 1602 Guilford ave.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1922

17

I HEREBY CERTIFY, That I attended deceased from June, 1922, to July 20, 1922,

that I last saw her alive on July 19, 1922

and that death occurred, on the date stated above, at 8.16 a. m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Septic endocarditis

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? 1602 Guilford Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Gross & Clinical

(Signed) A Schmitz, M. D.

, 19 (Address) 1107 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 22nd 1922
20 UNDERTAKER	ADDRESS
George Schulling & Son	126 E Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66108 HEALTH DEPARTMENT—CITY OF BALTIMORE 3 D 66108

CERTIFICATE OF DEATH. 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (St.) (Ward)

2-FULL NAME Cora Luckett Fawcett

(a) RESIDENCE NO. 2917 N Calvert ST., 12 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 55 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Christopher Fawcett

6 DATE OF BIRTH (month, day, and year): About—1867

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
55	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Luckett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Leonardtown Maryland

12 MAIDEN NAME OF MOTHER: Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Leonardtown Maryland

14 Informant: Chas. C. Fawcett (husband)
(Address) 2917 N Calvert St City

15 Filed JUL 20 1922, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922 to July 18, 1922

that I last saw her alive on July 18, 1922

and that death occurred, on the date stated above, at 3 15 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholangitis - Cholelithiasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 13, 22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. W. Bynum, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: July 21- 1922

20 UNDERTAKER: [redacted]
(WILLIAM P. [redacted], Assistant)

ADDRESS 100 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [redacted] CATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 66109 — PLACE OF DEATH — 179 — D 66109 — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1325 Hull St — 24 — St.; WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anastasia Parkinson

(Residence in Baltimore: No. 1325 Hull St — St.; ... yrs. ... mos. ... ds.)

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH: February 14, 1851 (Month) (Day) (Year)

7 AGE: 71 yrs. 5 mos. 5 ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 500

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Nicholas Shally

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Malone

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Parkinson
(Address) 1325 Hull St.

15 Filed JUL 21 1922 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 19 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 19, 1922, that I saw h[illegible] alive on July 18, 1922, and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) ... yrs. ... mos. 3 ds

Contributory (SECONDARY) Mitral Regurgitation
Chronic Interstitial Nephritis
(Duration) ... yrs. ... mos. 15 ds.

(Signed) Thos F. Stevens M. D.
July 20, 1922 (Address) 2878 Huntsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Peters Cem — DATE OF BURIAL: July 21 1922

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 1422 Light St.

Spec.—1-10-21—M&T—1500 Bks.

D 66110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66110

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 W Lanvard ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Ellis

(a) RESIDENCE No. 1112 W Lanvard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	53	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police man 061

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Frances Ellis

(Address) 1112 W Lanvard St

15 Filed JUL 21 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1922.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1921, to July 18, 1922.

that I last saw h alive on July 18, 1922.

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) — yrs. 9 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Physical

(Signed) Thos Norton Jno M. D.

7/20, 1922 (Address) 888 N Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

Jos. W. Moulton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66111

CERTIFICATE OF DEATH.

31 D 66111

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 134 W. Hamburg ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. Jos. Moulton

(Residence in Baltimore: No. 134 W. Hamburg St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Single

6-DATE OF BIRTH, May 7, 1897
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
25 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) ..... Yd.

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Chas. Moulton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie M. Powell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. W. Moulton (Brother)

(Address) 134 W. Hamburg St.

15- JUL 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from about Dec. 30 1921, to July 18, 1922, that I saw him alive on July 15, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) about 8 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Bramwell M. D.

July 20, 1922 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	July 22, 1922

20-UNDERTAKER John H. Toadvine ADDRESS 142 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 66112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66112

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Exeter ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leib Shurr

(Residence in Baltimore: No. 124 N. Exeter St.; 15 yrs., mos. ds.)

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH. unknown (Month), (Day), 1847 (Year)

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired Tailor
(b) General nature of industry, business, or establishment in which employed (or employer). 080

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Dagold

(Address) 416 N. Exeter St

15-

Filed JUL 21 1922, 191

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12 1922, to Jul. 3 1922, that I saw him alive on July 17 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis and arteriosclerosis

(Duration) 5 ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy instant death

(Duration) yrs. mos. ds.

(Signed) Benj. Slaton M. D.

Jul. 20, 1922 (Address) 2306 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Cemetery DATE OF BURIAL, July 21, 1922

20-UNDERTAKER Pikesville Funeral Home ADDRESS 1439 E. Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

D 66113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66113

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 Brookfield Ave ST., 13 WARD)

2-FULL NAME Jochel Schwartzman

(a) RESIDENCE No. 2028 Brookfield Ave ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Schwartzman

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 75 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Schwartzman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1434 E Baltimore

15 Filed JUL 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 20, 1922, that I last saw h[illegible] alive on July 20, 1922, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Postmortem Anemia Cachexia

(Signed) S. Wolman, M. D.

7-21-1922 (Address) 2444 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bala

DATE OF BURIAL: 7-21 1922

20 UNDERTAKER: Jack Lewis

ADDRESS: 1434 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66114

74-001

CERTIFICATE OF DEATH.

D 66114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Asquith St., 9th WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margareta List

(a) RESIDENCE NO. 1717 Asquith ST., 9th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick List

6 DATE OF BIRTH (month, day, and year) Dec 18th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Ringstadt, Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ringstadt Germany

14 Informant Milton List

(Address) 1717 N. Asquith St.

15 Filed JUL 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1922, to July 19, 1922,

that I last saw her alive on July 19, 1922,

and that death occurred, on the date stated above, at 7 45 p m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) ? yrs. ? mos , ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorhage

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Fomby, M. D.

7/20, 1922 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 22 1922
20 UNDERTAKER	ADDRESS
Louis Heeman	928 E Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66115

CERTIFICATE OF DEATH.

113 D 66115

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 949 W. Lombard St. 18 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Hopwood

(Residence in Baltimore: No. 949 W. Lombard St. St.; yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Feb. (Month) (Day) 1922 (Year)

7-AGE: ..... yrs. 5 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: Harry Hopwood

11-BIRTHPLACE OF FATHER (State or Country): City

12-MAIDEN NAME OF MOTHER: Annie Hacker

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hagenbuch

(Address) 941 W. Lombard

15-

FILED JUL 21 1922

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 20 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Heart & Dirt

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) H K Gormley M. D.
(Coroner)

July 21 1922 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western — DATE OF BURIAL: July 21 1922

20-UNDERTAKER: Robert L. Little — ADDRESS: 1 W. Edmondson Ave

D 66116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 66116

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 18 S. Dallis ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Joseph Diamond.

(Residence in Baltimore: No. 181 S. Dallis St. (yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Trainer
(b) General nature of industry, business, or establishment in which employed (or employer) Jockey

9-BIRTHPLACE, (State or Country). Richmond Va.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Diamond

(Address) 181 S Dallis st

15-

JUL 21 1922 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Pneumatic Tuberculosis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bowel Complaint

(Duration) yrs. mos. 1 ds.

(Signed) C. C. Gladden M. D.

July 21 1922 (Coroner) (Address) 1437 N Bway

*Give the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, National Cemetery

DATE OF BURIAL, 7/22, 19 22

20-UNDERTAKER, Sol Simson & Bro

ADDRESS 1117 Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

Smielinska

HEALTH DEPARTMENT—CITY OF BALTIMORE

66117

CERTIFICATE OF DEATH.

114 D 66117

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2020 Portugal ST., 7 WARD)

2-FULL NAME Catherine Smielinska

(a) RESIDENCE NO. 2020 Portugal ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	77	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Grantowicz (Address) 2020 Portugal St

15 Filed JUL 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 18, 1922, that I last saw her alive on , , , 1922, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in the city

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) A. G. Freeborn M. D.

7/20 1922 (Address) 918 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 22 1922
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66118 ✓ 139 D 66118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST. 70 WARD)

2-FULL NAME Mrs Annie L. Fowler.

(a) RESIDENCE NO. 1820 Fairmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Fowler

6 DATE OF BIRTH (month, day, and year): Feb 21 1880.

7 AGE: Years 42 Months 4 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mercy Hosp Md

PARENTS

10 NAME OF FATHER: John Doyle.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Timmins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Record

(Address)

15 Filed JUL 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1922, to July 20, 1922, that I last saw h[illegible] alive on July 20, 1922, and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

Uremia Tabetic

? (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Hemorrhage

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typ & Segro

(Signed) J. J. Kerrigan III, M. D.

19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 7/24/22

20 UNDERTAKER: Geo A Foley Fulton

ADDRESS: Fayette

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66119

CERTIFICATE OF DEATH.

113 D 66119

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 915 N. Central Ave ST., 10 WARD)

2-FULL NAME Catherine Holthaus

(a) RESIDENCE NO. 915 N. Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? Life mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Philip J. Holthaus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Minnie Wild

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr. Philip J. Holthaus

(Address) 915 N. Central Ave

15 Filed JUL 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from 7-4, 1922 to 7-20, 1922 that I last saw h alive on 7-20, 1922 and that death occurred, on the date stated above, at 8 55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Abdo. Colitis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Infirmary

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. J. Reynolds M. D.

7-21-22 (Address) 700 N. Holl Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL: July 21 1922

20 UNDERTAKER: Henry Horch Sons ADDRESS: 1301 E. Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gumbert

D 66120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66120

135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caspar H. Gumbert

(a) RESIDENCE. NO. 214 W. Payson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 9 1866

7 AGE — Years: 56 Months: 3 Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Joseph L. Gumbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Etersteger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Barbara Gumbert
(Address) 214 W. Payson St.

15 Filed JUL 21 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to July 20, 1922, that I last saw him alive on July 20, 1922, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Gastric Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 17-1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Hulet Wilkerson, M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 24 1922

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E. Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Fiorarantii Sarchiaponi

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6612I

CERTIFICATE OF DEATH.

D 6612I

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 755 W. Lexington ST.; 4 WARD) 113

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fiorarantii Sarchiapone

(Residence in Baltimore: No. 755 W. Lexington St.; ——— yrs., 10 mos. ——— ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 18, 1921.
(Month) (Day) (Year)

7-AGE, ——— yrs. 10 mos. ——— ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Vinci Sarchiapone

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Liducca

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vinci Sarchiapone.

(Address) 755 W. Lexington

15-

Filed JUL 21 1922 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 20th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 18th 1922, to July 20th 1922, that I saw him alive on July 20th 1922, and that death occurred on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis
+ Cardiac Asthenia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions 6 hrs.

(Duration) yrs. mos. ds.

(Signed) E. B. Culbreth M. D.

7/20, 1922 (Address) 1901 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery

DATE OF BURIAL, July 21, 1922.

20-UNDERTAKER W. M. Rowlett

ADDRESS 230 N Green

N.B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 66122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66122

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Poplar Grove ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John James Caveghen

(a) RESIDENCE NO. 501 Longwood St. ST., ... WARD ....

(Usual place of abode)

Length of residence in city or town where death occurred Abt 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susanna Caveghen

6 DATE OF BIRTH (month, day, and year) Nov. 9th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward for St. Johns College Anna

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Island of Malta (State or country) England

PARENTS

10 NAME OF FATHER James Caveghen

11 BIRTHPLACE OF FATHER (city or town) Island of Malta (State or country) England

12 MAIDEN NAME OF MOTHER Severina De Carlo

13 BIRTHPLACE OF MOTHER (city or town) Island of Malta (State or country) England

14 Informant Mrs. Susanna Caveghen (Address) 501 Longwood St.

15 Filed JUL 21 1922 ROBERT [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 19 22

17

I HEREBY CERTIFY, That I attended deceased from June, 1920, to July 20, 1922.

That I last saw h[illegible] alive on July 20, 1922

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart,

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma and Chronic Nephritis (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Sign[illegible]

(Signed) Joseph W Zeiler, M. D.

(Address) 1123 Poplar Grove.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine — DATE OF BURIAL July 24 1922

20 UNDERTAKER Jos B Cook — ADDRESS 1003 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 66123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3028 W North Ave ST., 45 WARD)

2-FULL NAME Mary A Marker

(a) RESIDENCE NO. 3028 W North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sam'l W Marker

6 DATE OF BIRTH (month, day, and year) May 10th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	60	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Catonsville Md.

PARENTS

10 NAME OF FATHER Frdk Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz Ruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Frederick Meisel 512 Inglesides Ave.

15 Filed JUL 21 1922 ROBERT [illegible] Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1921, to July 19th, 1922

that I last saw her alive on July 17, 1922

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Rectal Carcinoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Metastasis

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of Radium only

Was there an autopsy? Consultants

What test confirmed diagnosis?

(Signed) Chas E Parker M. D.

7/20 19 Address 3123 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem Lutheran Catonsville DATE OF BURIAL 7/21 1922

20 UNDERTAKER Jos B Cook ADDRESS 1003 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C 66124

1-PLACE OF DEATH

City of BALTIMORE: (No. 1944 W. Franklin St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Wesley Trott

(Residence in Baltimore: No. 1944 W. Franklin St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. October 5th 1856
(Month) (Day) (Year)

7-AGE. 65 yrs. 9 mos. 14 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Patrolman
(b) General nature of industry, business, or establishment in which employed (or employer). 561

9-BIRTHPLACE, (State or Country). Calvert Co., Md.

PARENTS.

10-NAME OF FATHER. Samuel Trott

11-BIRTHPLACE OF FATHER, (State or Country). Calvert Co. Md.

12-MAIDEN NAME OF MOTHER. Margaret Harrison

13-BIRTHPLACE OF MOTHER, (State or Country). Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David S. Trott

(Address) 403 N. Payson St.

15- JUL 21 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19th, 192-
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

July 19 1922 (Address) 700 E. Lombard St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western	July 22 1922

20-UNDERTAKER.	ADDRESS
J. B. Cook	1003 W. Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 66125

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-0 D 66125

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp (ST.) (WARD)

2-FULL NAME Mrs. Mary Connolly

(a) RESIDENCE NO. 3012 Edmondson Ave (ST.) WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Connolly

6 DATE OF BIRTH (month, day, and year) Mch. 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer at home

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Connolly

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Nelson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Mr. & Mrs. Connolly
(Address) 3012 Edmondson Ave.

15 Filed JUL 21 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to July 19, 1922,
that I last saw her alive on July 19, 1922
and that death occurred, on the date stated above, at 11:00 a.m.
The CAUSE OF DEATH* was as follows:

Cardiac Failure
Arteriosclerosis
Chronic Nephritis
Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
7/20, 1922 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 22 1922

20 UNDERTAKER	ADDRESS
Jos Block	1093 Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Artery Sclerosis.
Operation for gangrene.
Not Luetic. Not
Luetic. No further
history.

Spec.—1-10-21—M&T—1500 Bks.

D 66126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1807 Hanneman Ave

REGISTERED NO.

CITY OF BALTIMORE: (No. 1807 Hanneman Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Tomlin

(a) RESIDENCE NO. 1807 Hanneman Ave ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 29 1906

7 AGE: Years 15 Months 6 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Helper in Candy Factory

(b) General nature of industry, business, or establishment in which employed (or employer): Candy Making

(c) Name of employer: Rockdale Candy Co

9 BIRTHPLACE (city or town) (State or country): Edgemere Md

PARENTS

10 NAME OF FATHER: Leon A Tomlin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mullica Hill N J.

12 MAIDEN NAME OF MOTHER: Theresa M Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bucks Co Penn.

14 Informant (Address): Leon A Tomlin (Father) 1807 Hanneman Ave

15 Filed JUL 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1922 to July 19, 1922.

that I last saw her alive on July 19, 1922

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Usual Symptoms

(Signed) C. C. Macloneer, M. D.

July 20, 1922 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: July 22 1922.

20 UNDERTAKER: Millard B Callender

ADDRESS 1805 Hanneman Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66127

CERTIFICATE OF DEATH.

44 D 66127

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1315 W. Mosher St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Chuck

(Residence in Baltimore: No. 1315 W. Mosher St.; 5 yrs., ...mos., ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: May (Month) 16 (Day) 1884 (Year)

7-AGE: 33 yrs. 2 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hamilton Lee

(Address) 1121 N. Carey St.

15-

FILED JUL 21 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer (Stomach)

(Duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

July 21 1922 (Address) 2502 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, 7-22 1922

20-UNDERTAKER, George H. Holland ADDRESS 1631 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66128

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Elsinor ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude B. Towner

(a) RESIDENCE. No 2400 Elsinor ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jay F. Towner

6 DATE OF BIRTH (month, day, and year) Apr. 29. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Jos. Bonn

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mary J. Culley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Jay F. Towner (Address) 2400 Elsinor ave

15 Filed JUL 21 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20" 1922

17 I HEREBY CERTIFY, That I attended deceased from April 20" 1922 to July 20" 1922, that I last saw her alive on July 19 1922, and that death occurred, on the date stated above, at 3.40 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Myocarditis

Left Hemiplegia Uraemia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Perryman Md.	July 22 1922

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66129

D 66129

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1444 N Carey ST., 15 WARD)

2-FULL NAME James Anderson

(a) RESIDENCE NO. 1444 N Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Fannie Anderson

6 DATE OF BIRTH (month, day, and year) March 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day & Job work

(c) Name of employer Balto Md.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louisa Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Fannie Anderson
(Address) 1444 N Carey St

15 Filed Robert F. Harrison, Registrar
Burial Permit Clerk.
JUL 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922, to July 20, 1922, that I last saw him alive on July 20, 1922 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Fray, M. D.

, 1922 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery DATE OF BURIAL July 21 1922

20 UNDERTAKER James A. Pearce ADDRESS 1313 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66130

CERTIFICATE OF DEATH.

44 D 66130

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Sloan.

(a) RESIDENCE. NO. Preston & Valley Sts. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frostburg, Md.

PARENTS

10 NAME OF FATHER John Sloan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Ward,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Sister Florence, Preston & Valley Sts.

15 Filed JUL 21 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19. 1922

17 I HEREBY CERTIFY, That I attended deceased from November, 19.., to ..., 19.., that I last saw her alive on July 16, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Pylori)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July 19, 1922 (Signed) F. A. Warner, M. D. (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	July 22 1922

20 UNDERTAKER ADDRESS

H. C. Niedefeld 914 Gremm

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B-66131

CERTIFICATE OF DEATH.

X 179 D 66131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Devereaux

(a) RESIDENCE. No. 304 Brooklyn Pk. Blvd. WARD. Richmond, Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Elizabeth Devereux

6 DATE OF BIRTH (month, day, and year) Dec 15 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) Cardiff
(State or country) S. Wales

PARENTS

10 NAME OF FATHER William Devereux

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. Wales

12 MAIDEN NAME OF MOTHER Margaret Lewis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. Wales

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Monument & Broadway

15 Filed JUL 21 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1922, to July 20th, 1922, that I last saw h.. alive on July 20th, 1922, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema following Circulatory failure. Anaemia.

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis.

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of July 16 - 22

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Chemistry

(Signed) Claude S. Beck, M. D.

19—(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	July 21 1922
20 UNDERTAKER Jos. Block	ADDRESS 1003 W. Balto

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66132

CERTIFICATE OF DEATH

90 D 66132

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 4113 Penhurst Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna Marie Javille

(Residence in Baltimore: No. 4113 Penhurst Ave St.: 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Aug. 26, 1847 (Month) (Day) (Year)

7 AGE: 74 yrs. 10 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Johan Jenke

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Floyd

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Taylor
(Address) 4113 Penhurst Ave

15 Filed JUL 21 1922, 191
Robert F. Harrison, Burial Permit Clerk. REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 19, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1922, to July 19 1922, that I saw h— alive on July 19, 1922, and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds

Contributory (SECONDARY) Prostration near Coma

(Duration) yrs. mos. 1 ds.

(Signed) Lemuel F. Nelson M. D.
July 21, 1922 (Address) 901 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: July 22 1922

20 UNDERTAKER: J. B. Cook — ADDRESS: 1003 N. Balto

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66133

CERTIFICATE OF DEATH.

1640 D 66133

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 S. Linwood Ave ST.; 1 WARD)

2-FULL NAME Jacob Durm

(a) RESIDENCE. NO. 715 S Linwood Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Durm

6 DATE OF BIRTH (month, day, and year): Dec 11-840

7 AGE: Years 81 | Months 9 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Penna

PARENTS

10 NAME OF FATHER: John Durm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Rowek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Rayner 715 S. Linwood Ave

15 Filed: Robert P. Harrison, Registrar

UL 21 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to July 19, 1922

that I last saw h alive on July 19, 1922

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Infirmities of Old age

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell M. D.

July 20, 1922 (Address) 1644 Haworth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Co. — DATE OF BURIAL: July 22 1922

20 UNDERTAKER: Margaret J. Lupus — ADDRESS: 1111 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66134

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-02

D 66134

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 5147 Park & Leighton Road 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eudora Louise Lauenbach

(a) RESIDENCE. No. 5147 Park & Leighton Ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 5 mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw. Lauenbach

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years: Over 70 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10 NAME OF FATHER: Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER: Mckenney

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Lillian Mason

(Address) 2727 Pinkney Ave

15 Filed JUL 21 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20 1922 to July 20th 1922

that I last saw her alive on July 20th 1922.

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
& Hypostatic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an uperation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Leo. H. Lauenbach M. D.

7-20-1922 (Address) 2214 N. Charles Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: July 22 1922

20 UNDERTAKER: W. J. Kennard Son

ADDRESS: Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66135

CERTIFICATE OF DEATH.

Registered No. C .....

1-PLACE OF DEATH

City of BALTIMORE (No. 2125 St. Homewood Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luther Pue Hutcheson

(Residence in Baltimore: No. 2125 Homewood St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: June 7 (Month) (Day) 1868 (Year)

7-AGE: 54 yrs. 6 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): self

9-BIRTHPLACE (State or Country): Maryland

PARENTS

10-NAME OF FATHER: John G. Hutcheson

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Sallie M. Purnell

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia A. Hutcheson

(Address) 2125 Homewood Ave

15-

Filed ..... 192 .....

Robert F. Harrison,

Registrar.

Burial Permit Clerk

JUL 21 1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 20 (Day) 22 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

192 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	7/24 1922
20-UNDERTAKER.	ADDRESS.
Jos. J. Tickner & Sons	North Penna Ave

D 66136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66136

CERTIFICATE OF DEATH

Registered No. C.....

1-PLACE OF DEATH: Pronounced Dead at St. Joseph's Hosp.

City of BALTIMORE: (No. Bear Cork Statenid N. E. R. R. St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Ford N. Lotz

(Residence in Baltimore: No. 2403 Edmondson Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Mar. 11 (Month) (Day) 1874 (Year)

7-AGE: 48 yrs. 4 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work: Operator 078

(b) General nature of industry, business, or establishment in which employed (or employer): W. R. & E. Co

9-BIRTHPLACE (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John V. Lotz

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Elizabeth Schmidt

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Katherine Lotz

(Address) 2403 Edmondson Ave

15- FILED 1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

L 21 1922

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 20 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocuted (Accident)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Edwin Blades M. D.

(Coroner)

July 20/22 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: 7/24 1922

20-UNDERTAKER: Wm. J. Tickner & Son

ADDRESS: North & Pena

Spec.—1-10-21—M&T—1500 Bks.

Remond S. Zamanski.

D 66137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 S. Ann St., 7 WARD)

2-FULL NAME Remond S Zamanski

(a) RESIDENCE NO. 515 S. Ann. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fmale	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Zamanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen Burzy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant M. F. Sadowski. (Address) 705 S. Ann St.

15 Filed ..... 19 ..... Robert P. Harrison., Registrar

JUL 21 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 19 22

17

I HEREBY CERTIFY, That I attended deceased from 7/20, 19 22, to 7/22, 19 22,

that I last saw h alive on 7/22, 19 22,

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs 4 yrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. H. Bullock, M. D.

7/21, 1922 (Address) 1600 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. DATE OF BURIAL July 22 1922.

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S. Ann

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Frank M. Drozd.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 66138

CERTIFICATE OF DEATH

113 D 66138

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 S Ann St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank M Drozd

(Residence in Baltimore: No. 240 S St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Mal

4-COLOR OR RACE Wht

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH Sept 21 (Month) ..... (Day) 22 (Year)

7-AGE 10 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE (State or country) Baltimore

PARENTS

10-NAME OF FATHER Thomas Drozd

11-BIRTHPLACE OF FATHER (State or country) Poland

12-MAIDEN NAME OF MOTHER Mary Skorpinska

13-BIRTHPLACE OF MOTHER (State or country) Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Drozd

(Address) 2405 Ann

15- Robert P. Harrison,

Filed ..... 191 ..... REGISTRAR

Jul 21 1922 Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July (Month) 21 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to, July 20 1922, that I saw h.... alive on July 20 1922, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

..... (Duration) ..... yrs ..... mos. 3 ds.

Contributory (SECONDARY) Cardio Pneumonia

..... (Duration) ..... yrs ..... mos. ..... ds.

(Signed) W. J. Hayonek M. D.

July 21 1922 [Address] 804 Aliceanna

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL St. Stanislaus Cem

DATE OF BURIAL July 22. 1922.

20-UNDERTAKER W F Sadowski.

ADDRESS 705 S. Ann St.

Spec.—1-10-21—M&T—1500 Bks.

D 66139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66139

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 E Lombard ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Heidel

(a) RESIDENCE NO. 1913 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Heidel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amalia Heidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Heidel (Address) 1913 E Lombard

15 Robert P. Harrison, Registrar

Filed JUL 21 1922 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to July 20, 1922, that I last saw her alive on July 19, 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma "breast"

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 1920 or 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) Geo. Heller, M. D.

July 21, 1922 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 22 1922

20 UNDERTAKER Wendell Dyffel & Son — ADDRESS 378 N

IMPORTANT: THIS CERTIFICATE IS THE BASIS FOR PERMANENT RECORDS. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

66140

D 66140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 247 S. Chester ST., 1 WARD)

2-FULL NAME Edward Grochowski

(a) RESIDENCE NO. 247 S Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ' yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 20-22

7 AGE: Years — Months: 2 — Days: 29 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Kostanty Grochowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Cecilia Muskowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Kos. Grochowski 247 S Chester St

15 Filed 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/21 1922

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1922 to July 20th 1922

that I last saw h[illegible] alive on July 20th 1922.

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amelia E. Lick M. D.

7/21 1922 (Address) 1711 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: July 22 1922

20 UNDERTAKER: Wm Trautwein — ADDRESS: 1101 Eastern Ave

22 1922

IMPORTANT. BE EARLY, WRITE CAPITAL LETTERS AND THIS BLANK MUST BE FILLED OUT IN ITS ENTIRETY. PHYSICIANS should be careful in the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66141

CERTIFICATE OF DEATH.

74-001 D 66141

1-PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3010 (St.) Garrison Ave (WARD) 45

2-FULL NAME George W. Tatum Jr.

(a) RESIDENCE NO. 3010 (St.) Garrison Ave (WARD) _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Alice Tatum

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George W Tatum

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Ellen Downer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Alice Tatum 3010 Garrison Ave

15 Filed 7/21, 1922 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1921, to July 21, 1922,

that I last saw ~~him~~ alive on July 20, 1922,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

& Hemiplegia

(duration) 7 yrs. — mos — ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hemiplegia

(Signed) Henry Dyce, M. D.

7/21, 1922 (Address) 1100 Nathan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md — DATE OF BURIAL 7-24-1922

20 UNDERTAKER E & B. Earle — ADDRESS 115 E West St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

L 22 1922

D 66142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66142

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1127 Shields alley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Sanders

(Residence in Baltimore: No. 1127 Shields alley St.: 1 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	black.	single

6-DATE OF BIRTH, January (Month) 11 (Day) 1920 (Year)

7-AGE, 1 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country) Not known

12-MAIDEN NAME OF MOTHER Maddie Poe

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maddie Flick

(Address) 1127 Shields Alley

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

22 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pleo-Colitis

(Duration)..... yrs..... mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration)..... yrs..... mos. 2 ds.

(Signed) J. J. Hennessy (Coroner.) M. D.

July 21, 1922 (Address) 702 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, July 22 1922

20-UNDERTAKER David Taylor

ADDRESS 516 Pa Ave

CAUSE OF DEATH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also be important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66143

REGISTERED NO. 16-007 D 66143

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (ST.:) (WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Vogel

(a) RESIDENCE. (Usual place of abode) No. 902 E. Pratt St ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	11	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Vogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Stuhmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ..., 19 ... Registrar

JUL 22 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to July 21, 1922, that I last saw her alive on July 21, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Amoeba)

(duration) unknown — yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Multiple Abscesses -

(duration) unknown yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Stool Culture.

(Signed) Horace G. Thurst, M. D.

7/21, 19 22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	July 22 1922
20 UNDERTAKER	ADDRESS
Wendell Dyffe & Son	326 N

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66144

CERTIFICATE OF DEATH.

179 D 66144

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 23 WARD)

2-FULL NAME Edward Spurman

(a) RESIDENCE NO. 1936 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-14-1877

7 AGE: Years 44; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Patrick Spurman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Mrs August Klemsmith 110 E- Gretting

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-1922

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to July 21, 1922,

that I last saw him alive on July 21, 1922,

and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Hemmings M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 7/24 1922

20 UNDERTAKER Wm Cook

ADDRESS 502 E Monk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

22

D 66145 (See Letter attached) D 66145

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 W. 23rd St ST.: 12 WARD)

2-FULL NAME Susie V. Flenory

(a) RESIDENCE. NO. 115 W. 23rd St ST., 12 WARD. 1

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1845 ~~Oct 17 1845~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76 Yrs	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Warren Flenry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Henrietta V. Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Caroline Co

14 Informant (Address): John S. Bacc 115 W. 23rd

15 [illegible] 19 Registrar: Robert P. Harrison,

2[illegible] 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 19VV

17 I HEREBY CERTIFY, That I attended deceased from June 20 . 1919 . to July 20 . 19VV.

that I last saw her alive on July 20 . 19VV.

and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertention

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert L. Mitchell, M. D.

July 21 19VV (Address) 711 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery | DATE OF BURIAL: 7/22 19VV

20 UNDERTAKER: Wm Cook | ADDRESS: 502 E N St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT L. MITCHELL, M. D.
2112 MARYLAND AVENUE
BALTIMORE, MD.

E. Hampton Jones, M.D.
Commissioner of Health.
City.

Dear Doctor Jones:

Through an error in stating date of birth of
Mrs. Susie V. Fleming, who died July 20-1920 Oct 22-1844
was given. This date of birth should be Oct 20-1845.
Will you please attend to this change in the death
certificate.

Very truly yours
Robert L. Mitchell

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66146

CERTIFICATE OF DEATH.

113 D 66146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2318 Vanderhorst Lane ST., 8 WARD)

2-FULL NAME Philip Leiber Jr.

(a) RESIDENCE NO. 2318 Vanderhorst Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 13 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Philip Leiber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Maria Doell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Philip Leiber

(Address) 2315 Vanderhorst Lane

Filed JUL 22 1922, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 19 22 to July 21 19 22.

that I last saw h alive on July 21, 19 22.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhea.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Ernest C. Kellett M. D.

July 21, 19 22 (Address) 838 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 22 1922
20 UNDERTAKER	ADDRESS
Frank A. Fink	916 N. Howard St.

Robert P. Harrison, Burial Permit Clerk

NOTE—MARRIAGE, MILITARY, OR OTHER STATISTICAL RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 66147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66147

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1315 N. Bond ST., 8 WARD)

2-FULL NAME Mary C. Dochringer

(a) RESIDENCE NO. 1315 N. Bond ST., WARD Lancaster Co.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred About 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Dochringer

6 DATE OF BIRTH (month, day, and year) Feb. 5th, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer) 0 3 7

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Pa.
(State or country)

PARENTS

10 NAME OF FATHER John Weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Meyers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John Dochringer
(Address) 1315 N. Bond St.

15 Filed , 19 Registrar

2[illegible] 1922 [illegible] Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to July 21, 1922

that I last saw h[illegible] alive on July 20, 1922.

and that death occurred, on the date stated above, at 10:10 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook M. D.

7/22, 1922 (Address) 413 N. Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster, Pa. DATE OF BURIAL 7/22/1922

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66148

CERTIFICATE OF DEATH.

111-001 D 66148

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 N Calhoun (ST.) 16 (WARD)

2-FULL NAME Geo H Downs

(a) RESIDENCE. NO. 1017 N Calhoun (ST.) WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Downs

6 DATE OF BIRTH (month, day, and year) Feb 14-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 840

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nellie Downs (Address) 1017 N Calhoun St

15 Filed ....., 19.... Registrar

L 28 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to July 20, 1922, that I last saw h alive on July 21, 1922, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer - Perforated
Physical exhaustion

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Catarrhal Gastritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination Microscopic

(Signed) Edward Short, M. D.

July 21 1922 (Address) 1812 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL 7-22 1922

20 UNDERTAKER Geo H Close

ADDRESS 1400 Pulaski

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

D 66149

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-B 66149

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2632 Florence St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Mullo

(Residence in Baltimore: No. 2632 Florence St.; yrs., 1/2 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, July (Month) 20 (Day) 1922 (Year)

7-AGE, — yrs. — mos. — ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Mullo

11-BIRTHPLACE OF FATHER (State or Country), S C

12-MAIDEN NAME OF MOTHER Lucenia Dale

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Lucenia Dale

(Address) 2632 Florence St

15-

Filed July 22, 1922, 191.... Robert F. Harrison. Registrar.

Burial Permit Clark.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner)

July 21, 1922 (Address) 3632 Reisterstown

(*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, July 20, 1922

20-UNDERTAKER Mrs Robert F. Ellis ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D. 66150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66150

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Funk

(a) RESIDENCE NO. 20 N. High St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 39 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed 2 2 1922, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1922

17 I HEREBY CERTIFY, that I attended deceased from July 11, 1922, to July 13, 1922, that I last saw him alive on July 11, 1922, and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm Riley, M. D.

, 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 2 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66151

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital (St.:) No (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Goebel

(a) RESIDENCE. No. Unknown St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer): 019

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk

L 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1922

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1918 to July 18, 1922, that I last saw her alive on July 17, 1922 and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Cornell M. D.

7/20/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: JUL 2 1922 19

20 UNDERTAKER

ADDRESS

Commissioner of Health,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66152

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 66152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Fremont ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Watkins

(a) RESIDENCE NO. 1207 Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 769

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Henry Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Mary E. Penn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm. Watkins

(Address) 1207 Fremont Ave

15 Filed JUL 22 1922, 19

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1922, to July 21, 1922

that I last saw h alive on July 20, 1922

and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab.

(Signed) Jno W. Hoff, M. D.

(Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: July 24 1922

20 UNDERTAKER: McGuinn & Conrad

ADDRESS 4203 Reisterstown Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 22 1922

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66153

CERTIFICATE OF DEATH.

90 D 66153

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 719 Park ave ST., 11 WARD)

2-FULL NAME Jesse C Reese.

(a) RESIDENCE NO. Wallace Ave near Carroll Road ST., WARD.....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. - mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband.

6 DATE OF BIRTH (month, day, and year) Dec 10, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	41	~~7~~	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertiser. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew J Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant E. L. Hanson

(Address) 719 Park Ave.

15 Filed ....., 19..... Registrar Robert P. Garrison,

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to July 9, 1922.

that I last saw h[illegible] alive on July 9, 1922.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) ..... M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 22 1922

20 UNDERTAKER Harry H. Witzke ADDRESS N 3116 Fremont

22 1922

I. B. [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66154

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1724 Darley av ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Clark.

(a) RESIDENCE. No. 724 Darley av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 30 /22

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: none 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Frank C. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Florence Jenstrom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

11 Informant (Address): Florence Jenstrom 1724 Darley av

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk

JUL 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20 1922 to July 1922, that I last saw her alive on July 21 1922, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Premature 6 mo.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John W. Sanderson M. D.

1922 (Address) 1714 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 7/22 1922

20 UNDERTAKER: J. Frew Mills Co. Ltd

ADDRESS: 100 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] PA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

V 003
159 D 66155

D 66155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2940 Edmondson ST., 16 WARD)

2-FULL NAME Edw Doherty

(a) RESIDENCE No. 2940 Edmondson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1922

7 AGE — Years: — Months: — Days: 6
If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ooo
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edw Doherty
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Gladys Pindle
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Edw Doherty
(Address): 2940 Edmondson Ave

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 22, 1922,
that I last saw him alive on July 21, 1922,
and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Starvation due to
congenital Stricture of the
Oesophagus

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? X-Ray

(Signed) M. E. O'Neill, M. D.
7/22, 1922 (Address) 108 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL 7/24/22, 19

20 UNDERTAKER: Ford Bailey Sutton — ADDRESS 8 Paca St

N. B.—WRITE PLAINLY, WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7 22 1922

Robert F. Harrison,
Burial Permit Clerk.

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66156

CERTIFICATE OF DEATH.

D 66156

REGISTERED NO. 15 - 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2802 Wallbrook Av ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adeline E Long.

(a) RESIDENCE NO. 2802 Wallbrook Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, ~~or divorced~~
HUSBAND of (or) WIFE of Leonard a Long

6 DATE OF BIRTH (month, day, and year) Apr. 24. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	82	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ~~None~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alexander Stall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. N. E. Hamilton

(Address) 2802 Wallbrook Av

15 Filed JUL 23 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to July 22, 1922, that I last saw h alive on July 22, 1922, and that death occurred, on the date stated above, at 12 10 a m.

The CAUSE OF DEATH* was as follows:

Diabetis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood

(Signed) Alice S. Parkhurst, M. D.

, 19 (Address) 1410 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 24 1922

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. Northam

NAME, RESIDENCE AND OCCUPATION OF INFORMANT SHOULD BE GIVEN IN THIS SPACE PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66157

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66157

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 E Oliver ST., 8 WARD)

2-FULL NAME Margaret M. Courtney

(a) RESIDENCE NO. 2528 E Oliver ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept. 19 1921

7 AGE: Years — Months: 10 — Days: 4 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James F. Courtney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rose M. Roney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr James F. Courtney (Address) 2527 E Eliza St

15 Filed JUL 23 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23rd 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/21, 1922, to 7/23, 1922, that I last saw h[illegible] alive on 7/22, 1922 and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Entero Colitis

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Wood, M. D.

July 23 1922 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 24 1922

20 UNDERTAKER: Henry Horck Son — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66158

CERTIFICATE OF DEATH.

132

REGISTERED NO. D 66158

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Louis Leatherman

(a) RESIDENCE NO. 2048 Maltese Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Louis Leatherman

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 59 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rabbi

(b) General nature of industry, business, or establishment in which employed (or employer): 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Leatherman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mary Liebermann (Address) 2048 Maltese ave

15 Filed JUL 23 1922 ROBERT R. KRAMER Registrar

Burial Permit Dr

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from July ~~23~~, 19 22 to July 23, 19 22 that I last saw him alive on July 23, 19 22 and that death occurred, on the date stated above, at 1:10 a m.

The CAUSE OF DEATH* was as follows:

Vesical Calculus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Cerebral Embolus Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 8, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hamil J. Finegan M.D.

July 23, 1922 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehren Meh Rd — DATE OF BURIAL: July 23 1922

20 UNDERTAKER: Jack Leurs — ADDRESS: 1439 E Baltimore

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66159

CERTIFICATE OF DEATH.

113 D 66159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 694 W Mulberry ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jackson

(a) RESIDENCE No. 694 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: — Months: 10 Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: George Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Emma Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Emma Jackson 694 W Mulberry

15 Filed JUL 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1922, to July 21, 1922

that I last saw h[illegible] alive on July 21, 1922

and that death occurred, on the date stated above, at 12.46p m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Lowell M. D.

, 19 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Pr Cem

DATE OF BURIAL: July 23 1922.

20 UNDERTAKER: Samuel Kemmey

ADDRESS: 518 N Bond St

X. BE WRITTEN PLAINLY WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66160

CERTIFICATE OF DEATH.

× 45 D 66160

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE { No. St. Joseph's Hospital (WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. Mary Hildeberta

(a) RESIDENCE. No. Notre Dame - Augusta St WARD.

(Usual place of abode) (If nonresident give city or town and State) New York

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept - 7 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) Rochester, N. Y.
(State or country)

PARENTS

10 NAME OF FATHER Xavier Hauser

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Hauser

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sister Mary Dionisia
(Address) Notre Dame Cinquotti St

15 Filed JUL 23 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17

I HEREBY CERTIFY, That I attended deceased from July 19 . 19 22 to July 22 . 1922

that I last saw her alive on July 22 . 19 22

and that death occurred, on the date stated above, at 10:5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Duc. Colon

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 20, 22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. W. Kinney, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Rd.	July 24 19
20 UNDERTAKER	ADDRESS
Frank A. Sick	915 N. Gay St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66161

D 66161

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Nursery and Childs Hosp. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles White

(a) RESIDENCE. No. 804 Winston Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State).

Length of residence in city or town where death occurred 0 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ********

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) *****

(c) Name of employer ********

9 BIRTHPLACE (city or town) (State or country) Union Bridge Md.

PARENTS

10 NAME OF FATHER Harhan White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Virginia Euchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant M. Varon M- Chase

(Address) 604 Winston Ave

15 Filed JUL 23 1922 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 22, 1922, that I last saw him alive on July 21, 1922, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative Ilio-colitis

(duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Mal Heuzler M. D.

, 19 (Address) 700 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	7/24 1922
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 66162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3211 Elliott ST., 26 WARD)

2-FULL NAME George W Froehlich

(a) RESIDENCE NO. 3211 Elliott ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L. Froehlich

6 DATE OF BIRTH (month, day, and year) Aug. 19-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	36	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Froehlich

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Ompesta

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Amelia Nitzcher

(Address) 3211 Elliott St.

15 Filed JUL 23 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to July 21, 1922, that I last saw him alive on July 19, 1922 and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. McAvoy, M. D.

7/22, 1922 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL July 24, 1922

20 UNDERTAKER Sirkler & Sirkler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH PENCIL OR INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66163

CERTIFICATE OF DEATH.

90 D 66163

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Hickory & Overlea Ave ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lydia F. Bennett

(a) RESIDENCE. NO. 306 S Ann ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank P. Bennett

6 DATE OF BIRTH (month, day, and year) Feb 3, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 037

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Nicholas L. Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Connie Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frank P. Bennett
(Address) 306 S. Ann St

15 Filed JUL 23 1922, 19 ROBERT A. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to July 22, 1922 that I last saw h[illegible] alive on July 21, 1922 and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. F. Cochran M. D.

7.22. 19 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL July 25 1922

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1734 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66164

159-003

CERTIFICATE OF DEATH.

D 66164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N. Rose ST.: 7 — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Eisenhauer

(a) RESIDENCE. NO. 504 N. Rose ST., 7 — WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 20 — 1922

7 AGE — Years: — Months: — Days: 2 and 14 hours — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

000

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Louis Eisenhauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary McClaskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Louis Eisenhauer
(Address): 504 N. Rose st.

15 Filed JUL 23 1922 ROBERT R. KRAUSER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 — 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21 —, 1922, to July 22, 1922

that I last saw her alive on " " , 1922

and that death occurred, on the date stated above, at 7 05 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into the intestines and passing by rectum with every stool

(duration) — yrs. — mos. 2½ ds.

CONTRIBUTORY (Secondary): —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted, if not at place of death? Probably imperfect development

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Much blood in the stools

(Signed) Edwin B. Finby, M. D.

7/24/1922 Address 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick Cem — DATE OF BURIAL: July 24 22

20 UNDERTAKER: J Smith — ADDRESS: 2008 Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

✓ 66165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66165

CERTIFICATE OF DEATH.

X 90

D 66165

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) BC Mt Hope Retreat (St.) 28th (Ward)

2-FULL NAME Mrs Della Van Wie

(a) RESIDENCE. (No.) Mt Hope Retreat (St.) 28th (Ward) Pat.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Van Wie

6 DATE OF BIRTH (month, day, and year) March 23- 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fort Plain N. Y.

PARENTS

10 NAME OF FATHER E. Wiles

11 BIRTHPLACE OF FATHER (city or town) Fort Plain N.Y. (State or country)

12 MAIDEN NAME OF MOTHER M. Ann Lettman

13 BIRTHPLACE OF MOTHER (city or town) Fort Plain N Y. (State or country)

14 Informant (Address) Record of Mt Hope Retreat Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 23rd, 1922 to July 23rd, 1922 that I last saw h alive on July 22nd, 1922, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis -

abt (duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Residual Psychosis

abt (duration) 0 yrs. 7 mos. 0 ds.

18 Where was disease contracted if not at place of death? Columbia Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

July 23rd, 1922 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fort Plain - N.Y. DATE OF BURIAL: July 23/ 1922

20 UNDERTAKER: STEWART & POWER [redacted] (WILLIAM P. [redacted])

ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

66166

D 66166

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66166

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat (St.) 28 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Theresa Winn

(a) RESIDENCE. No. Mt Hope St., 28 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Mr Winn

6 DATE OF BIRTH (month, day, and year) About 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) (?) Maryland

PARENTS

10 NAME OF FATHER Louis Winn

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Maryland

12 MAIDEN NAME OF MOTHER Florence Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Maryland

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md-

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 . 1920. to July 22nd . 1922. that I last saw h er alive on July 22nd . 1922. and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Melancholia -

abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Eckhart Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery . M. D.

July 23rd . 192 2 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frostburg - Md. DATE OF BURIAL July 23/ 1922

20 UNDERTAKER [redacted] ADDRESS [redacted] W. NORTH AVE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66167

D 66167

CERTIFICATE OF DEATH.

15-107-003
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Mary's Home (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Virginia Pickfield

(a) RESIDENCE. (No.) Gilmor & Pratt (St.) (Ward.)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE — Years: 73 — Months — Days — If LESS than 1 day, hrs. or mln.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer): D.C.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Sister Catharine Angela (Address) All Saints Convent

15 Filed ..., 19... Registrar.

JUL 24 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from 1900, to July 12, 1922, that I last saw h[illegible] alive on July 12, 1922, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Suppurating sore in [illegible] Exhaustion and [illegible] abscess following Pneumonia Contracted (Duration) 2 yrs. 1 mon. 0 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) [illegible] M. D.

7/22. 1922 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cem Waverly — DATE OF BURIAL: July 24 1922

20 UNDERTAKER: Hennessy Jenkins & Sons Co — ADDRESS: Mt Cathedral Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66168

CERTIFICATE OF DEATH.

34 D 66168

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1310 Eutaw Place ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice Beirne Blackford

(a) RESIDENCE NO. 1310 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Blackford

6 DATE OF BIRTH (month, day, and year) Sept 25th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER John Beale Steenbergen

11 BIRTHPLACE OF FATHER (city or town) Mt Jackson (State or country) Virginia USA

12 MAIDEN NAME OF MOTHER Mary Beirne

13 BIRTHPLACE OF MOTHER (city or town) Winchester (State or country) W. Virginia USA

14 Informant Lewis D Blackford (Address) 10 South St Baltimore

15 JUL 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23d 1922

17 I HEREBY CERTIFY, That I attended deceased from March, 1912, to July 23d, 1922, that I last saw her alive on July 22d, 1922, and that death occurred, on the date stated above, at 9:10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Spine

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Prossus Paralysis of Legs, Bladder & Rectum (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at Place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Wm M. Dabney, M. D.

July 24, 1922 (Address) Ruxton, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 25 1922
20 UNDERTAKER	ADDRESS
Henry A. Tenbrink & Son Inc	Richard & Hamilton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66169 D 66169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 1519 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Mactier Warfield

(a) RESIDENCE. NO. Intonium ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Metcalf Warfield ~~Elizabeth Davis~~

6 DATE OF BIRTH (month, day, and year) May 18, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER R. Emory Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant R. Emory Warfield

(Address) Ruxton-Baltimore

15 Filed JUL 24 1922 . 19 ROBERT R. KNAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17

I HEREBY CERTIFY, That I attended deceased from July 20 . 1922 . to July 22 . 1922

that I last saw h im alive on July 22 . 1922

and that death occurred, on the date stated above, at 5:40 ~~p.m.~~ a.m.

The CAUSE OF DEATH* was as follows:

Rupture of the liver

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Thrown by a horse at Cockeysville.

Did an operation precede death? Yes Date of July 20

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Edmund M Howard Jr. M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 7-25 1922

20 UNDERTAKER Emory Hunting & Sons Co

ADDRESS McCulloh Orchard

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66170 HEALTH DEPARTMENT—CITY OF BALTIMORE OB 66170

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 830 Greenmount Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Robinson

(a) RESIDENCE. No. 830 Greenmount Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Earl Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chesterfield Co. S. C.

12 MAIDEN NAME OF MOTHER Maggie Streeter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chesterfield Co. S. C.

14 Informant Earl Robinson (Address) 830 Greenmount Ave

15 Filed JUL 24 1922 19 ROBERT H. ARMSTRONG Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to July 23, 1922, that I last saw her alive on July 22, 1922, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH was as follows:

Atelectasis

CONTRIBUTORY (Secondary) Premature birth (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto. Md (duration) yrs. 8 mos. ds.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. C. Robinson M. D.

7/22/1922 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery DATE OF BURIAL July 24 1922

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66171

CERTIFICATE OF DEATH.

1/13 66171

1-PLACE OF DEATH 2315- Hunters Alley

CITY OF BALTIMORE: (No. 2315- Hunters) ST.: 12 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dosthra Bassel

(a) RESIDENCE. NO. 2315- Hunters St- ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced (write the word): Smgle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single Child

6 DATE OF BIRTH (month, day, and year): Dec 16 1921

7 AGE: 1 Years 7 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Bassel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Grace Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Farther William Bassel 2315- Hunters St

15 Filed JUL 24 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 21, 19 22, to July 23, 19 22, that I last saw h... alive on July 23, 19 22, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Pylone Spasms over

(duration) yrs. mos. 5- ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. A. Johnson, M. D.

, 19 (Address) 211-E-20 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laural Cemetery

DATE OF BURIAL: July 24 19 22

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS: 725- Ashland Ave

N. B.—THIS BLANK, WITH ALL QUESTIONS ANSWERED, IS A PERMANENT RECORD AND SHOULD BE TYPEWRITTEN. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Due to diarrhoea & enteritis

Date of Birth - taken from reported birth Certificate

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66172

CERTIFICATE OF DEATH.

4 100-001

D 66172

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 Diamond ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl H. Smith

(Residence in Baltimore: No. 320 Diamond St.; Life yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 28 (Month) Nov (Day), 1920 (Year)

7-AGE, 1 yrs. 7 mos. 25 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimd

PARENTS.

10-NAME OF FATHER, Waverly Smith

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Lottie Peterson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Smith

(Address) 320 Diamond

15-

Filed ..... 191.....

ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

JUL 24 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1922, to July 23 1922, that I saw h[illegible] alive on July 22 1922, and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William E. Burtons M. D.

July 23, 1922 (Address) 62 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery

DATE OF BURIAL, July 23., 1922

20-UNDERTAKER Wm Robert A Elliott

ADDRESS 1726 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66173

38D 66173

CERTIFICATE OF DEATH.

REGISTERED NO. ..

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. .... ST., 4 WARD)

2-FULL NAME Mattie Campbell.

(a) RESIDENCE NO. 521 Tonolloga ST., ... WARD ....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: William Campbell

6 DATE OF BIRTH (month, day, and year): 1887.

7 AGE: Years 35. Months — Days — If LESS than 1 day, hrs. or min. ....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Cook

(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER: Henry Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant (Address): Bay View Hospital Balt, Md.

15 Filed JUL 24 1922 19 ROBERT F. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1922 to July 22 1922 that I last saw h[illegible] alive on July 22 1922 and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Fever.

CONTRIBUTORY (Secondary): Syphilitic Epilepsy (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ....

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Necroscopical

(Signed) N. Goldsmith Eldridge M. D.

7/24 1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: July 26 1922

20 UNDERTAKER: Jno Robert A Elliott — ADDRESS 1725 Oakland

A. B.—WHITE PAPER, WITH CARBON BACK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 66174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66174

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Bruce St. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Joseph Smith.

(Residence in Baltimore: No. 703 Bruce St. St.; ..... yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored.	

6-DATE OF BIRTH, March 21 —, 1922
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 4 mos. .....ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER William J. Smith

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Annie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF ~~MY KNOWLEDGE~~.
(Informant) Wm Smith
(Address) 703 Bruce St

15-
Filed JUL 24 1922 ROBERT P. LAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22 —, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1922 to July 22 1922, that I saw him ~~alive~~ dead on July 22 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Decomposition Intestinales

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Leyer M. D.

July 22, 1922. (Address) University Hospital Clinic

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	July 24, 1922

20-UNDERTAKER Daniel Easton. ADDRESS 916 Eutaw

Spec. Fil. Bks.

D 66175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66175

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 Maryland ave ST., 25 WARD) 2nd Part

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Waldo Dill

(a) RESIDENCE No. 123 Maryland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 31 1920

7 AGE: Years 1 Months 6 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West York (State or country)

PARENTS

10 NAME OF FATHER George W Dill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Highland Town

12 MAIDEN NAME OF MOTHER Sarah A. McMenamin

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Sarah A Dill

(Address) 123 Maryland Ave

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 21, 1922, that I last saw him alive on July 21, 1922 and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W H Hall, M. D.

, 19 (Address) Hampden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet cemetery

DATE OF BURIAL: July 24 1922.

20 UNDERTAKER: James Dignan & Son

ADDRESS: 1000 S. Broadway St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 66176

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3231 Elliott ST., 26 WARD)

2-FULL NAME Philomena Speelman

(a) RESIDENCE NO. 3231 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Orion E. Speelman

6 DATE OF BIRTH (month, day, and year) Sept. 20-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John B. Foreman

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Burton

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Edgar McKay Wilhelm

(Address) 731 Greenmount ave

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1922 to July 22 1922

that I last saw her alive on July 22 1922

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver + intestines

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Stitlow M. D.

7/28, 1922 (Address) 314 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 25 1922

20 UNDERTAKER Zinkler + Zinkler

ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T- 1500 Bks.

Mander

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66177.

CERTIFICATE OF DEATH.

× 135

D 66177.

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St. WARD)

2-FULL NAME Thomas E. Mander

(a) RESIDENCE NO. Still Pond = ST. Kent WARD Co., Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER W E Mander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wilson Mander
(Address) Betterton Kent Co Md

15 JUL 24 1922 Filed ....., 19.... ROBERT R. KRAUSER
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May - 18 -, 1922, to July - 22 -, 1922

that I last saw him alive on July - 22 -, 1922

and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Sup. Prostatitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) general Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-18-22 7-22-22

Was there an autopsy? no

What test confirmed diagnosis? op. findings

(Signed) Newton E Purr, M. D.

7/22/1922 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Betterton Kent Co

DATE OF BURIAL 7/25 1922

20 UNDERTAKER Jones & Toulson

ADDRESS 12-14 W Green St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66178

CERTIFICATE OF DEATH.

1-001

D 66178

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph. Hospt. ST., 12 WARD)

2-FULL NAME John Contese

(a) RESIDENCE NO. Glen Edward ar 2 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married Woman

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: About 37. Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Edward Tonkon

(Address) 12-14 N. Glen St

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 1 , 19 22 , to July 22 , 19 22 ,

that I last saw h in alive on July 22 , 19 22 ,

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Riley , M. D.

, 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cem — DATE OF BURIAL: 7/25 1922.

20 UNDERTAKER: Jones & Tonkon — ADDRESS: 12-14 N Glen St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66179

D 66179

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1463 Columbia Ave ST.) 21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena E. Funk

(a) RESIDENCE. No. 1463 Columbia Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Robt W. Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mamie E. McHoole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Robert W. Funk, (Address) #1463 Columbia Ave

15 Filed JUL 21 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1922, to July 23, 1922, that I last saw h[illegible] alive on July 23, 1922, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

7/23, 1922 (Signed) R. Keller Hemming, M. D.

(Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.,	July 25. 1922
20 UNDERTAKER	ADDRESS
W. F. Ladowski,	905 S. Ann St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 - 1-001

D 66180

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 506 N. Eden ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Ralph

(a) RESIDENCE. No. 506 N. Eden ST., WARD.

(Usual place of abode) Life time (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 18 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 29 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4 m	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Ralph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Tresie Parlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant James Ralph (Father)

(Address) 506 N. Eden st.

15 FILED JUL 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1922, to 7/21, 1922, that I last saw h[illegible] alive on 7/21, 1922, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab

(Signed) R J Lyerly, M. D.

, 19 (Address) 1424 E. Monument st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	July 23 1922
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66181

161-001

CERTIFICATE OF DEATH.

D 66181

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 248 W. Hoffman St.; 11th WARD)

2-FULL NAME Charles Augustus Water

(a) RESIDENCE. No. 248 W. Hoffman St., 10th WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: negro

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 21, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Eugene Water

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Christine Field

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis, Md.

14 Informant: Eugene Water
(Address): 248 W. Hoffman St

15 Filed . 19

JUL 24 1922

ROBERT R. KRAUTER.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1922

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1922, to July 23, 1922;

that I last saw h alive on July 23, 1922;

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Louis A. Johnson M. D.

. 19 (Address) 211 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dist Zion [illegible]	July 24 1922

20 UNDERTAKER: [illegible] Brown Funeral Directors

ADDRESS 107 [illegible]

NOTE—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66182

CERTIFICATE OF DEATH.

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 807 (St.) Pennington Ave (WARD) 13

2-FULL NAME Samuel M. Wallach

(a) RESIDENCE NO. 807 (St.) Pennington Ave (WARD) 6

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND (or) WIFE of: Carrie Wallach

6 DATE OF BIRTH (month, day, and year): March 16, 1877

7 AGE — Years: 45 — Months: 4 — Days: 6 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Millinery

(c) Name of employer: Salesman

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Meyer Wallach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Mathilda Hecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mr. Stanley Wallach

(Address): 807 Pennington Ave

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/22/ 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 22, 1922, that I last saw h[illegible] alive on July 22, 1922, and that death occurred, on the date stated above, at 4 0 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Rheumatic Carditis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wolman, M. D.

, 19 (Address) 2444 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. DATE OF BURIAL 7/24/ 1922

20 UNDERTAKER: David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66183

D 66183

CERTIFICATE OF DEATH.

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 W Mulberry ST., 19 WARD)

2-FULL NAME Margaret L. Ward

(a) RESIDENCE NO. 1603 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Ward

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Baylor Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nellie Grasham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Robt Ward 1603 W Mulberry St

15 Filed JUL 24 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-9, 1922, to 7-23, 1922, that I last saw h~ alive on 7-23, 1922 and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(duration) 1 yrs. 1 mos. x ds.

CONTRIBUTORY (Secondary) Uremia

(duration) x yrs. x mos. 21 ds.

18 Where was disease contracted if not at place of death? in Balto City

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) P. Bulkley, M. D.

July 24, 1922 (Address) 1124 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Maryland | DATE OF BURIAL July 25 1922

20 UNDERTAKER Harwood & Wright | ADDRESS 1364 N Carey

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66184

CERTIFICATE OF DEATH

100 D. 66184

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 14 WARD)

2-FULL NAME Charles Minor

(a) RESIDENCE NO. 512 N Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE Years 82 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bayview Hospital Records

15 JUL 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/6/1922, 19 . to 7/22/1922, 19 . that I last saw him alive on 7/22/1922, 19 . and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Mckee M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Br Cemetery

DATE OF BURIAL July 25 1922

20 UNDERTAKER Edward E. Wright

ADDRESS 3641 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Lots.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66185

CERTIFICATE OF DEATH.

129 D 66185

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Hull St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Nagle

(a) RESIDENCE. No. 1226 Hull ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Charlotte C. Nagle

6 DATE OF BIRTH (month, day, and year) Jan 5 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Daniel Nagle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Carlotta Nagle (Address) 1226 Hull St.

15 JUL 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6 1921, to July 20 1922, that I last saw h— alive on July 18 1922, and that death occurred, on the date stated above, at 11.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) W. T. Peabody, M. D.

7/21, 1922 Address) 638 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	July 24 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66186

CERTIFICATE OF DEATH.

Registered No. C.....

D 66186

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer Gold

(Residence in Baltimore: No. 213 N Milton Ave. St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Single

6-DATE OF BIRTH: April (Month) 11 (Day) 1911 (Year)

7-AGE: 11 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): School

9-BIRTHPLACE (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Jacob Gold

11-BIRTHPLACE OF FATHER. (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Bessie Cohen

13-BIRTHPLACE OF MOTHER. (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto St

15- JUL 24 1922

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 23 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto accident

(Duration) yrs. mos. 2 hrs

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. 26 ds.

(Signed) Geo. Clinton Bladen (Coroner.)

July 23 1922 (Address) 143 N Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: North Pa. & Germ Hill Rd DATE OF BURIAL: July 24 1922

20-UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 66187. HEALTH DEPARTMENT—CITY OF BALTIMORE D 66187.

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 S Regester St ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Lynn

(a) RESIDENCE NO. 6 S Regester St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John R. Lynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ethel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Maria Lynn (Address) 6 S Regester St

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922.

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1922, to July 23, 1922, that I last saw him alive on July 21, 1922, and that death occurred, on the date stated above, at 11. Am m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Ritchey M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patricks — DATE OF BURIAL: July 24, 1922

20 UNDERTAKER: Wendell Appel & Son — ADDRESS: 32 Lum St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66188

CERTIFICATE OF DEATH.

164 D 66188

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 S. Regester ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rome.

(a) RESIDENCE NO. 315 S. Regester ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH CONTRADICTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Rome.

6 DATE OF BIRTH (month, day, and year) June 13th 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
82	1	8	

8 OCCUPATION OF DECEASED Cigar Maker

(a) Trade, profession or particular kind of work Retired 12 years

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Simon Rome.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Lantman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William A. Rome.

(Address) 315 S. Regester St.

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1921, to July 21 1922.

that I last saw h[illegible] alive on July 20, 1922,

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

General Debility

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred A. Endrich, M. D.

July 22 1922 (Address) 8 S. Putnam St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S. National Cem. DATE OF BURIAL July 24th 1922

20 UNDERTAKER Lilly-Zeiler ADDRESS 4033 Mosh. Ave

Spec.—1-10-21—M&T—1500 Bks.

D 66189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 66189

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 E. Hamburg ST., 23 WARD)

2-FULL NAME Norman L Bryson

(a) RESIDENCE NO. 221 E Hamburg ST WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 24 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	16	4	5	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Special Delivery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) at Balto Post Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Bryson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary F Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Henry Bryson (Address) 221 E Hamburg st

15 JUL 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20 1922 to July 21, 1922

that I last saw h alive on July 21, 1922

and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. H. Campbell M. D.

July 24, 1922 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL July 25 1922

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66190 REGISTERED NO. C 57 D 66190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Huntingdon ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Raver

(Residence in Baltimore: No. 2606 Huntingdon ave St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 21 (Day), 1853 (Year)

7-AGE, 69 yrs. 11 mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Caleb Ishler

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Bapler

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Raver

(Address) 2606 Huntingdon

15- Filed JUL 24 1922, 191 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1922, to June 22 1922, that I saw h er alive on June 22 1922, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Gangrene both feet

6 weeks

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) 1 yrs. mos. ds.

(Signed) O R Wantz M. D.

July 22, 1922 (Address) 865 W. 36th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary Hampden

DATE OF BURIAL, July 24 1922

20-UNDERTAKER H M Routson

ADDRESS 2238 N Milton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

157095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66191

CERTIFICATE OF DEATH.

161-0B 66191

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hoyer, Jr.

(a) RESIDENCE. No. 1339 Asquith St. (City) St.) WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mrs. Walters (Grandmother) 299 Talbot St.

6 DATE OF BIRTH (month, day, and year) May 13, 1922

7 AGE: Years ____ Months 2. Days 7. If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: William Hoyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Walters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records,

JUL 24 1922

ROBERT R. KRAUTER Registrar

Vital Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 20, 1922, that I last saw h.. alive on July 20, 1922, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Birth Injury - Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No - Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? Autopsy -

(Signed) Horace G. Stewart, M. D.

7/21, 1922 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JUL 24 1922

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Eks.

D 66192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66192

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Hebrew Hosp. ST.: 13 WARD)

2-FULL NAME Mr. Harry Melman

(a) RESIDENCE. No. 2452 Druid Hill ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jobber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel Melman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Annie Melman
(Address) 2452 Druid Hill ave

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922, to July 23, 1922, that I last saw him alive on July 23 at 11 PM 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Perforation of sigmoid ulcer
c generalized peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforation of sigmoid ulcer

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/20/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isadore Hamer, M. D.

7/23, 1922 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	July 24 1922
20 UNDERTAKER	ADDRESS
A. Linnor & Bro	112 E. Balto St.

A. B.—PLEASE READ CAREFULLY—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

66193

HEALTH DEPARTMENT—CITY OF BALTIMORE

101

101-D 66193

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto. Md.

CITY OF BALTIMORE: (No. 771-Saratoga ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Rowe.

(a) RESIDENCE NO. 771-Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Rowe

6 DATE OF BIRTH (month, day, and year): 2/27/1897

7 AGE: Years 25 Months 5 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lay Laborer O&D

(b) General nature of industry, business, or establishment in which employed (or employer): Oyster industry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Crisfield Md. Somerset Co.

PARENTS

10 NAME OF FATHER: Douglas Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Crisfield Somerset Co.

12 MAIDEN NAME OF MOTHER: Sarah E. Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fairmount Md.

14 Informant (Address): Sarah Rowe 771 E Saratoga St

15 Filed JUL 24 1922 ROBERT R. [illegible], Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/22 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 1922 to 7/22, 1922, that I last saw him alive on 7/21, 1922, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert Lee Jackson M. D.

7/24 1922 (Address) 765-W Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmount Md

DATE OF BURIAL: July 26 1922

UNDERTAKER: Edward Beasley

ADDRESS: [illegible]

Spec.—1-10-21—M&T—1500 Bks.

Schreiber

D 66194 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D 66194
REGISTERED NO.

1-PLACE OF DEATH Municipal Hospital 3

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schreiber

(a) RESIDENCE NO. 1426 Eastern WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30 1857

7 AGE Years 65 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown. 7/22 1922

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hosp. Records.

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-1922

17 I HEREBY CERTIFY, That I attended deceased from 3-21-1922 to 7-22-1922, that I last saw h[illegible] alive on 7-22-1922 and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of spine ?

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

(Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: July 25 1922

20 UNDERTAKER: Kendall J. Dippel — ADDRESS: 370 [illegible]

S. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Phelonun Warren ✓

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66195

CERTIFICATE OF DEATH.

X 32

D 66195

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phelonun Warren

(a) RESIDENCE. NO. So Hampton, Va ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
22	—	—	—	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) So. Hampton Virginia.

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

11 Informant Hospital Records

(Address)

15 Filed JUL 24 1922 . 19

ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 20 . 1922 . to July 21 . 19 22

that I last saw him alive on July 21 . 19 22

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Laboratory + Spinal fluid

(Signed) M. Bloom, M. D.

19 Address Lakeside Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jane S. Crumpton Va	7-24 1922
20 UNDERTAKER Sam H Case Sons	ADDRESS 1450 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66196

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101-001 D 66196

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1148 N. Calhoun ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Staten

(Residence in Baltimore: No. 1148 N. Calhoun St.: 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOW(ER), OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Jan (Month) 4 (Day), 1865 (Year)

7-AGE, 57 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N-C-

PARENTS.

10-NAME OF FATHER, Benjamin Jones

11-BIRTHPLACE OF FATHER (State or Country), N-C-

12-MAIDEN NAME OF MOTHER Sarah Jones

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) 1148 N Calhoun St

(Address) John Staten

15- Filed JUL 24 1922 19..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1922, to July 22 1922, that I saw h[illegible] alive on July 22 1922, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (Duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) W. J. Coleman M. D.

July 23 1922 (Address) 2037 McCulloh St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet

DATE OF BURIAL, ... 7-25 1922

20-UNDERTAKER John W. Bosse & Son

ADDRESS Wm. Mahon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Enright

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66197.

CERTIFICATE OF DEATH

D 66197.

1 PLACE OF DEATH

Registered No. C 179

CITY OF BALTIMORE (No. 1208 N Patterson Park Ave St.; 8 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME. Sarah Enright

(Residence in Baltimore: No. 1208 N Patterson Park Ave St.; 2 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Aug (Month) 23, (Day) 1869 (Year)

7 AGE: 52 yrs. 6 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Dry Goods

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Timothy Enright

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Quinn

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Corcoran

(Address) 2087 N. Patterson Park Ave

15 Filed JUL 24 1922 J. H. Wilms REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 22 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to July 22 1922 that I saw h[illegible] alive on July 21, 1922, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

chronic interstitial Nephritis

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) arteriosclerosis

(Duration) 2 yrs. mos. ds.

(Signed) James M Fenton M. D.

July 24, 1922 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted. If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral — DATE OF BURIAL: July 25, 1922

20 UNDERTAKER: J. C. Friedfield — ADDRESS: [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66198

CERTIFICATE OF DEATH.

REGISTERED NO. 2231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tucker

(a) RESIDENCE. No. 436 Pulaski st. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Tucker Not stated

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER E. B. Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Laura Roach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records M. T. H.

15 Filed JUL 24 1922 J. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 23, 1922, that I last saw him alive on July 23, 1922, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Padaglucca M. D.

7-23-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet DATE OF BURIAL July 25 1922

20 UNDERTAKER George L. Schwab ADDRESS 1101 Eutaw Ave

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 66199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66199

CERTIFICATE OF DEATH.

-31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Quick Ave ST.; 26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Franke

(Residence in Baltimore: No. 24 Quick Ave St.; Life yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 24 (Day), 1892 (Year)

7-AGE, 30 yrs. 1 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 13

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles H. Becker

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Dowling

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Franke

(Address) 24 Quick Ave

15- Filed JUL 24 1922, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 21 (Day), 1922. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 6 1922, to July 21 1922, that I saw h[er] alive on July 21 1922, and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Valvular Heart

(Duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

July 21, 1922 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery DATE OF BURIAL, July 24 1922.

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Park Ave

Spec.—1-10-21—M&T—1500 Bks.

D 66200 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66200

CERTIFICATE OF DEATH. 174

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3807 Dalrymple Ave. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Margaret Nicklas

(a) RESIDENCE NO. 3807 Dalrymple Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13. 1857

7 AGE — Years: 65 Months: 1 Days: 10 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Nicklas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Daab

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dorothea Resch

(Address) 3807 Dalrymple ave

15 Filed July 24, 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 19 22, to July 23rd, 19 22,

that I last saw her alive on July 23rd, 19 22

and that death occurred, on the date stated above, at 8 20 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

July 25, 19 (Address) 1501 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: July 25 19

20 UNDERTAKER: A. Sander Sons ADDRESS: 1701 E. Eager

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Inflammation gall bladder. Not cancerous. No arteria sclerosis. No chronic organic heart disease. No nephritis. No further autopsy.

Spec.—1-10-21—M&T—1500 Bks.

D 66201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66201

CERTIFICATE OF DEATH.

X 24

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME June V. Gessler

(a) RESIDENCE NO. Bishop's Lane ST., Catonsville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: 1 yr. 6 mos. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: J. L. Gessler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: J. L. Gessler

(Address) Bishops Lane Catonsville Md

15 Filed JUL 25 1922, 19.. Registrar E. Wenn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1922 to July 23, 1922

that I last saw her alive on July 23, 1922

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) H. Draper M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 7-24-1922

20 UNDERTAKER: H. C. Brauning & Co. — ADDRESS 317 N Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

5-7213 D 66202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1/13 D 66202

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. ST.: (WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Thomas

(a) RESIDENCE. No. Centerville ST. WARD. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 4. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	—	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) (

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katharine Inman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17 1922, to July 24 1922, that I last saw h alive on July 23 1922, and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Diarrhoea (Not dysentery)

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine examination

(Signed) Horace G. Stewart, M. D.

7/24, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Centerville, Md. DATE OF BURIAL: 7/24/1922

20 UNDERTAKER: E. D. Fanning & Son - ADDRESS: 1931 E. Lafayette Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66203

HEALTH DEPARTMENT—CITY OF BALTIMORE

205-001

D 66203

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3410 Eastern Ave. ST., 76 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lewis Ruch

(a) RESIDENCE NO. 3410 Eastern Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 22-1922

7 AGE — Years — Months 1 Day — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Lewis Ellsworth Ruch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Anna C. Schaffer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Lewis Ellsworth Ruch (Address) 3410 Eastern Ave.

15 Filed JUL 24 1922 ROBERT R. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to July 23, 1922, that I last saw h— alive on July 23, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) C. V. B. Tilden, M. D.

7-24-1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: July 24 1922

20 UNDERTAKER: Tilly & Julian ADDRESS: 403 S. Wolfe

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of embolism unknown. Not instrumental delivery. Not premature birth. No injury at birth. No further history. No autopsy.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66204

CERTIFICATE OF DEATH.

16 D 66204

1-PLACE OF DEATH Mercy's Hospital

CITY OF BALTIMORE: (No. Lafayette & John Sts. ST.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Foote

(Residence in Baltimore: No. Walthoff Md St.; .....yrs., ...mos. 2 hrs. 35 min. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 22, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. .....mos. 1 ds.

If LESS than 1 day, 2 hrs. 35 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Mulford Foote

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Trieo Lautenhahn

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Duncan

(Address) Mercy's Hosp.

15- JUL 24 1922 191.. ROBERT H. KNAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1922, to July 23 1922 that I saw h.. in alive on July 23 1922 and that death occurred, on the date stated above, at 2.10 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis Congenital

..... (Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) E. E. Duncan M. D.

7-23-, 1922 (Address) Mercy's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western

DATE OF BURIAL, July 24, 1922.

20-UNDERTAKER J. R. Cook

ADDRESS 1003 W. Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66205

CERTIFICATE OF DEATH.

179 D 66205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 E Pennsylvania Ave WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter B. Ford

(a) RESIDENCE NO. 41 E. Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 7/18/1879

7 AGE: Years 43 Months 7 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: advertising

(b) General nature of industry, business, or establishment in which employed (or employer): Agent 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Geo W. Ford.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Adams D Ford 17 N Monroe St.

15 Filed JUL 24 1922 19 ROBERT C. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1922, to July 21, 1922

that I last saw him alive on July 21, 1922

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Renal Carcinoma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 [illegible] 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: 7/24 1922

20 UNDERTAKER: Jno J Doheny & Sons

ADDRESS: 13, 8 Light

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66206

CERTIFICATE OF DEATH.

113 D 66206

REGISTERED NO. ..

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Central Ave. ST.) 10 (WARD)

2-FULL NAME Margaret D. Staton

(a) RESIDENCE NO. 1039 N. Central Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov. 6 1921

7 AGE — Years: — Months: 8 Days: 17 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Lawrence M. T. Staton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Margaret C. Bradfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs. Frances K. Staton

(Address) 1039 N. Central Ave

15 JUL 24 1922

Health Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 22 – , 1922 to July 24 – , 1922, that I last saw her alive on July 23 , 1922 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Riland Jr. M. D.

7-24-1922 19 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 25 1922

20 UNDERTAKER: Henry Hoerle Sons — ADDRESS: 1301 E Eager

REGISTRAR.

Spec.—1-10-21—M&T—1500 Bks.

D 66207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66207

113

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 N Vincent ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Rowland Bishop

(a) RESIDENCE NO. 219 N Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23-1922

7 AGE Years Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel R. Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Bertha Funk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Samuel R Bishop (Address) 219 N Vincent

15 Filed JUL 24 1922 ROBERT R. KNOTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to July 23, 1922, that I last saw h alive on July 23, 1922, and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James H Lindenberger M. D.

7/24 1922 (Address) 1729 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto County

DATE OF BURIAL 7/25 19

20 UNDERTAKER Wm Cook

ADDRESS 1502 E Nor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66208

CERTIFICATE OF DEATH.

8 38 D 66208

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1813 N. Castle St. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Becker

(a) RESIDENCE. NO. 1813 N. Castle St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11-1821

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Emil Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretha Emrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Emil Becker
(Address) 1813 N Castle St.

15 JUL 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1922, to July 22, 1922, that I last saw her alive on July 22, 1922, and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cuculluan M. D.

7/22, 1922 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 7/25 1922

20 UNDERTAKER: Williams Co 16 — ADDRESS: 502 E Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88 D 66209

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 208 Calvin ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Emery Travers

(a) RESIDENCE No. 208 Calvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Travers

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 44; Months; Days; If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Travers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary C King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mame Travers

(Address) 208 Calvin St.

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Ap. 13, 1922, to July 21, 1922

that I last saw h[illegible] alive on July 21, 1922

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 0 yrs. 3 mos 8 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 0 yrs. 0 mos. 15 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? Physical tests

(Signed) R B Kenyon, M. D.

, 19 (Address) 609 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct

DATE OF BURIAL: July 26 1922

20 UNDERTAKER: N. R. Broun & Son

ADDRESS: 1051 N. Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Endocarditis acute.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
No chronic heart trouble. No further history.

Spec.—1-10-21—M&T—1500 Bks.

Davison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66210

CERTIFICATE OF DEATH.

179 D 66210

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 922 N. Mallington Ave (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Davison

(a) RESIDENCE NO. 922 N. Mallington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Nelson J. Davison

6 DATE OF BIRTH (month, day, and year) Mar 6 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Herman Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Sarah A Raymond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Nelson J. Davison

(Address) 922 N Mallington Ave

15 JUL 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922 to July 24, 1922 that I last saw h alive on July 22, 1922 and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) E. E. Harden M. D.

July 24, 1922 (Address) 1201 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fair Port N. Y. Cr.

DATE OF BURIAL: July 25 1922

20 UNDERTAKER: Robt Johnson

ADDRESS: 1122 N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6621F

CERTIFICATE OF DEATH.

161-001

D 6621F

REGISTERED No. C.....

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No..... ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Penniman

(Residence in Baltimore: No. Sterrson, Md St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 20 (Day), 1922 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Dobbin Penniman Jr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lucy T. Dawson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Wilson

(Address) Woman's Hospital

15- Robert P. Harrison,

Filed ....., 191.....

JUL 24 1922 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1922, to July 20 1922, that I saw h[illegible] alive on July 20 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... yrs. 10 Min. mos. ..... ds.

CONTRIBUTORY (Secondary) Premature for 6 hrs

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

July 20, 1922 (Address) Women's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSP

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health.

ADDRESS

Per. Wm. E. WOODALL

JUL 24 1922

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66212

CERTIFICATE OF DEATH.

111-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 2 WARD)

2-FULL NAME Alexander Rambol

(a) RESIDENCE NO. 102 S Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hellen Rambol

6 DATE OF BIRTH (month, day, and year): March 22 1886

7 AGE — Years: 35 Months: 4 Days: 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Julis Rambl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Rambl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Hellen Rambol 102 S Washington

15 July 24 1922, 19 Registrar: Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-25- 1922 to 7-23 1922,

that I last saw him alive on 9-23 1922,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Post Operative Pneumonia

(duration) yrs. mos 24 hours ds.

CONTRIBUTORY (Secondary) Gastric ulcer

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-19-22.

Was there an autopsy? Yes

What test confirmed diagnosis? Operation.

(Signed) Louis Faber, M. D.

7/24, 19 22 (Address) The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Park Cem.

DATE OF BURIAL: July 26 - 19 22

20 UNDERTAKER: Randall Appleton

ADDRESS: 3 Penna Ave

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CL 24 1922

Burial Permit Given

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66213

CERTIFICATE OF DEATH.

D 66213

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1424 Presstman ST., 15 WARD)

2-FULL NAME Joseph Young

(a) RESIDENCE NO. 1424 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Alex Young

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Brownell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Lillian Brownell
(Address) 1424 Presstman St

15 JUL 24 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to July 23, 1922, that I last saw him alive on July 22, 1922 and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. William Fray, M. D.

7/23, 1922 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	July 24 1922

20 UNDERTAKER James H. Lemmon ADDRESS 1303 Presstman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Emma Smith)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66214

CERTIFICATE OF DEATH.

X 114 D 66214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Myers Alley ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Smith

(a) RESIDENCE NO. 611 Dekalb St. WARD Port de Paix

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Mamie Young

(Address) 1 Dekalb St

JUL 24 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922, to July 23 1922, that I last saw h[illegible] alive on July 23, 1922, and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No (Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 7/25 19

20 UNDERTAKER Dulaney Luttrell

ADDRESS [illegible]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15 7310
D 66215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66215

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL St.: 9 Ward 74

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Day

(a) RESIDENCE. No. 1009 William St. City St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced (Or) WIFE of: ~~HUSBAND of~~ Lillian Hay (mother)

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1922.

7 AGE: Years —; Months 5; Days 22; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child. 000
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Rubin Hay.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.
12 MAIDEN NAME OF MOTHER: Lillian Sud
13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: JOHNS HOPKINS HOSPITAL
(Address)

15 Filed 7/29 19 22 Robert F. Harrison, Registrar

L 2 4 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922, to July 24, 1922, that I last saw h.C.L. alive on July 24, 1922, and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Furunculosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

7/29, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A.C. Md. DATE OF BURIAL: July 25 1922

20 UNDERTAKER: John F. Denny ADDRESS: 715 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 66216

Registered No. C.....

1-PLACE OF DEATH Pronounced Dead at University Hosp.

City of BALTIMORE: (No. Rosemont - Md. St. 4 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren Raymond Wrighoff.

(Residence in Baltimore: No. Rosemont Md. U.A.C.O. St.; yrs.. mos.. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Sgle

6-DATE OF BIRTH: July (Month) 27 (Day) 1910 (Year)

7-AGE: 12 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): U.A.C.O. Md.

PARENTS

10-NAME OF FATHER: Jno A. Wrighoff.

11-BIRTHPLACE OF FATHER (State or Country): Balto Co Md.

12-MAIDEN NAME OF MOTHER: Elz Knudel.

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno A. Wrighoff

(Address) Rosemont Md

15- 1922 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 24 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull caused by Injury struck by M. B. & O. R.R. Train

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Gordon M. D. (Coroner.)

July 24 1922 (Address) 117 W Baltimore St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: July 26 1922

20-UNDERTAKER: C. W. Dill

ADDRESS 3109 Frederick Ave.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66217.

CERTIFICATE OF DEATH

D 66217.

REGISTERED No. 8 112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1813 N. Callington Ave ST. WARD

2-FULL NAME Vincent Martin Gaulis

(a) RESIDENCE No. 1813 N. Callington Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Greif Bros

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Martin Gaulis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Adeline Lucy (daughter)

(Address) 1813 N. Callington Ave.

15 Filed JUL 24 1922 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17

I HEREBY CERTIFY, That I attended deceased from July 22 1922 to July 22, 1922, that I last saw him alive on July 22 1922, and that death occurred, on the date stated above, at 2.25 a. m.

The CAUSE OF DEATH* was as follows:

Acute indigestion

30 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation Heart

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? none

(Signed) George Abner Bowden, M. D.

7/22 1922 Address 1517 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	July 24 19

20 UNDERTAKER Jacob Frid Sons ADDRESS 428 S. Bond St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S phonetic state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66218

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66218

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 London Ave St. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Franklin Kendall

(a) RESIDENCE NO. 128 London Ave St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Todd

6 DATE OF BIRTH (month, day, and year) Feby 13-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer Retail

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Annes Co Md

PARENTS

10 NAME OF FATHER Jos K. Kendall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Knotts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary C Kendall

(Address) 2624 Guilford Ave

15 Filed JUL 24 1922, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 24 1922

17 I HEREBY CERTIFY That I attended deceased from July 18 1922 to July 24 1922, that I last saw h[illegible] alive on July 24 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows

Acute Anemia

(duration) yrs mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones, M. D.

July 24 (Address) Dover Del.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dover Ridge Cem DATE OF BURIAL July 26 1922

20 UNDERTAKER Harry M Ellen ADDRESS 1944 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66219

CERTIFICATE OF DEATH.

41 D 66219

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home Infirmary

CITY OF BALTIMORE: (No.) Broadway (or) Fairmount ST., (WARD) 27

2-FULL NAME Mrs. Walter C. Lantzberry.

(a) RESIDENCE NO. 5 Lon. Ave. ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs — mos. — ds. How long in U. S., if of foreign birth? 10 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Beatrice Lantzberry

6 DATE OF BIRTH (month, day, and year) April 23 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	34	3		

8 OCCUPATION OF DECEASED (PHYSICIST)

(a) Trade, profession or particular kind of work Physicist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Manchester England

PARENTS

10 NAME OF FATHER Alfred Lantzberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Frances Hyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Beatrice Lantzberry

(Address) 2617 Eutaw Place

15 Filed Jul 24 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/15/, 1922, to 7/23, 1922.

that I last saw him alive on 7/23, 1922,

and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Sarcoma - Trypotococcus Neoformans -

(duration) yrs. 8-10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Caytano Cancellare M. D.

, 19 (Address) Church Home Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL July 25 1922

20 UNDERTAKER Harry W. Ehlen ADDRESS 1919 W. Nord Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 66220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66220

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S ann ST., 2 WARD)

2-FULL NAME Tomas Krzystynski

(a) RESIDENCE NO. 523 S ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Victor Krzystynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Kent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Victor Krzystynski (Address) 523 S Ann

15 JUL 24 1922, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922 to July 24, 1922.

that I last saw h— alive on July 23, 1922

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

auto gastro intents
x Colitis.

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary DATE OF BURIAL July 25 1922

20 UNDERTAKER John F Weber ADDRESS 803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6622F

D 6622F

179

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 S East ave ST., 26 WARD)

2-FULL NAME Anthony Luczkowski

(a) RESIDENCE NO. 1011 S. East ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Anthony Luczkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Luczkowski (Address) 1011 S East ave

15 Filed JUL 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1922, to July 22, 1922, that I last saw him alive on June 21, 1922, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos 30, ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Colet V Athey Jr. M. D.

July 27 1922 Address 105 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL July 25 1922

20 UNDERTAKER John McWeber — ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66222

CERTIFICATE OF DEATH

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Goodman

(Residence in Baltimore: No. 241 N Dallas St.; Yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: male

4-COLOR OR RACE: Color

5-Single, Married, Widowed, or Divorced. (Write the word): Married

6-DATE OF BIRTH: Jan 2 (Month) (Day) 1897 (Year)

7-AGE: 25 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lab
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Washington D.C.

PARENTS:

10-NAME OF FATHER: John Goodman

11-BIRTHPLACE OF FATHER, (State or Country): Auburn

12-MAIDEN NAME OF MOTHER: Ella Brooks

13-BIRTHPLACE OF MOTHER, (State or Country): Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ezra Brooks

(Address) 241 n dallas st

15-

Filed JUL 25 1922 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: July 22 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull.
Homicide

(Duration) yrs. mos. 3 hrs

CONTRIBUTORY (Secondary) Stab

(Duration) yrs. mos. 36 ds.

(Signed) G. C. Blades M. D.
(Coroner.)

192 (Address) 1423 E Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery DATE OF BURIAL: July 24 1922

20-UNDERTAKER: Edward Bryan ADDRESS 1631 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66223

CERTIFICATE OF DEATH.

160

D 66223

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Essex ST., First WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elnora Bozman

(Residence in Baltimore: No. 2306 Essex St St., yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May 19, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Cuba

PARENTS.

10-NAME OF FATHER, Alexander Bozman

11-BIRTHPLACE OF FATHER (State or Country), Cuba

12-MAIDEN NAME OF MOTHER Margaret J. Kane

13-BIRTHPLACE OF MOTHER (State or Country), Cuba

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Bozman

(Address) 2306 Essex St

15-

Filed ....., 191....

JUL 25 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to July 23, 1922, that I saw her alive on July 22, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

(Signed) Alfred W. Bendach M. D.

July 24, 1922 (Address) 58 Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Paul's Cemetery

DATE OF BURIAL, July 25, 1922

20-UNDERTAKER H. Sander Sons

ADDRESS 1710 Pleasant

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66224

CERTIFICATE OF DEATH.

179 D 66224

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Orleans St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Butler

(a) RESIDENCE. NO. 1611 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Charlesdena Butler

6 DATE OF BIRTH (month, day, and year) mo? day? yr 1856

7 AGE: Years 66 | Months unknown | Days unknown | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Edna Watkins (nephew) 1611 Orleans St

15 Filed JUL 25 1922 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from January 1922 to July 22 19 22, that I last saw him alive on July 20 19 22, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Sale.

(Signed) R J Young M. D.

. 19 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen Cem.

DATE OF BURIAL: July 25 19 22

20 UNDERTAKER: Thos J. G. Locke

ADDRESS: 1302 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

D 66225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66225

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 8 WARD)

2-FULL NAME Jacob A. Hoffman

(a) RESIDENCE NO. 1804 N. Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonette Hoffman

6 DATE OF BIRTH (month, day, and year) Jan. 10 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	54	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer) Maidens Mannis Band

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Philip Hoffman

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna Arndt

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Antonette M. Hoffman
(Address) 1804 N. Register St

15 Filed JUL 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922 to July 24, 1922

that I last saw him alive on July 24, 1922

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Terminal pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Urinary Infiltration

Stricture (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of July 22, 1922

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) J. C. Feguson, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemy. DATE OF BURIAL July 26, 22

20 UNDERTAKER Henry Storck Son ADDRESS 1341 E Eager St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonorrhoea 25 yrs ago resulting in stricture.

Phoned by the physician

Spec.—1-10-21—M&T—1500 Bks.

Mary Rauh ✓

D 66226 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66226

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH St. Josephs Hospital

CITY OF BALTIMORE: (No. 9 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Mary Rauh

(a) RESIDENCE NO. Catalina & Oliver - St Josephs Hosp - Baltimore Co

(Usual place of abode) ST., WARD

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Not Known yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant St Josephs Hosp. Nurse (Address)

15 Filed JUL 25 1922 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 18 . 1922 to July 24 . 1922 that I last saw h alive on July 24 . 1922 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Chronic Colitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 19, 22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S W Kearney M. D.

. 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL July 26 1922

20 UNDERTAKER Henry Hordt Son ADDRESS 1301 E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66227

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.:) (Ward) 9

2-FULL NAME George Diebler

(a) RESIDENCE. No. 3533 Old York Rd. (Ward)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 18 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Philip Diebler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 25 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 1922 to July 24th, 1922; that I last saw him alive on July 24th, 1922, and that death occurred, on the date stated above, at 2-20 p.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea, not dysentery

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Horace G. Stewart, M. D.

7/29, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Cemetery Fullerton 2nd.	July 25 1922

20 UNDERTAKER Henry Wood & Son ADDRESS 1501 E. Eager St.

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Maria)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66228

CERTIFICATE OF DEATH.

74 D 66228

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1245 W Cross ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Mary Annie Mans

(Residence in Baltimore: No. 1245 W Cross St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept. (Month) 16th (Day), 1854 (Year)

7-AGE, 67 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Geo W. Fisher

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER , , , ,

13-BIRTHPLACE OF MOTHER (State or Country), , , , ,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George L Fisher

(Address) 917 Columbia Ave

15-

Filed ....., 191.....

JUL 25 1922

HUBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23rd (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16th 1922 to July 23rd 1922

that I saw her alive on July 23rd 1922

and that death occurred, on the date stated above, at 4.54 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Edema and Interstitial nephritis (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J E Poulton M. D.

7/24/22 (Address) 654 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet

DATE OF BURIAL, July 25, 1922

20-UNDERTAKER Knecht & Son

ADDRESS 1124 W Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54333 Ded

D 66229 — 1-PLACE OF DEATH

V

001

21 D 66229 — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Meyer

(a) RESIDENCE. No. 1022 Sefton St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 5 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	S — —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 26-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emil Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dorothy Knell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 25 1922 ROBERT A. KRAUTER, Assistant Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1922, to July 24, 1922, that I last saw him alive on July 24, 1922, and that death occurred, on the date stated above, at 1202 m.

The CAUSE OF DEATH* was as follows:

Meningitis, Staphylococcus.

(duration) yrs mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture -

(Signed) Horace G. Stewart, M. D.

7/24, 1922 (Address) Johns Hopkins Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

London Park July 25 1922

20 UNDERTAKER — ADDRESS

Knell & Son 1729 W Pratt st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66230

HEALTH DEPARTMENT—CITY OF BALTIMORE

52D 66230

CERTIFICATE OF DEATH.

Registered No. C .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 202 S. Durham St. / Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil H. Nordbruch

(Residence in Baltimore: No. 202 So. Durham St., St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. July 15 1870
(Month) (Day) (Year)

7-AGE. 52 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Henry Nordbruch

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Nordbruch

(Address) 202 So. Durham St

15-

Filed JUL 25 1922. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, July 24 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Appendicitis

(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
(Coroner)

July 25 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, In Deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
I. H. Gelman Co.	July 27 1922
20-UNDERTAKER.	ADDRESS
Peter Mechans	Easter A.

Spec.—1-10-21—M&T—1500 Bks.

D 6623I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 6623I
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2220 N. Calvert St. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Octavia Lipscomb

(a) RESIDENCE NO. 2220 N. Calvert St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Winfield Lipscomb

6 DATE OF BIRTH (month, day, and year): Sept. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 060

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hanover Co. Va.

PARENTS

10 NAME OF FATHER: Joseph Paraley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hanover Co Va.

12 MAIDEN NAME OF MOTHER: Jane White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hanover Co Va.

14 Informant: Miss Lelia Lipscomb
(Address): 2220 N. Calvert St.

15 Filed JUL 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 27, 19 22, to July 24, 19 22

that I last saw h[illegible] alive on July 24, 19 22

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Hemiplegia

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stanley Gonzales M. D.

7/25 19 22 (Address) 1900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 26 19 22
20 UNDERTAKER	ADDRESS
Joseph L. Cox	1032 N. Calvert St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66232

CERTIFICATE OF DEATH.

114

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 927 McDonough St. WARD 7

2-FULL NAME Viola James-Holmes

(a) RESIDENCE. No. 927 McDonough St. WARD.

(Usual place of nbode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Holmes

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General domestic

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER William H. Jones

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Md.

12 MAIDEN NAME OF MOTHER Maud Hill

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant William H. Jones (Address) 927 McDonough St.

15 Filed JUL 25 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1922 to July 24, 1922.

that I last saw h[illegible] alive on July 23, 1922

and that death occurred, on the date stated above, at 4:10 p m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal colonal

(duration) yrs. 1 mos. 19 ds.

CONTRIBUTORY (Secondary) Dysentery

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of

Was there an autopsy? no,

What test confirmed diagnosis? Clinical

(Signed) J. H. C. Johnson M. D.

7/24/1922 (Address) 1320 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL mt-Auburn Cem

DATE OF BURIAL July 27 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66233

CERTIFICATE OF DEATH.

31

D 66233

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. Municipal Tuberculosis Hospital WARD 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Johnson (Wyatt)

(a) RESIDENCE. No. 2549 Oak st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

Off time

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Johnson

6 DATE OF BIRTH (month, day, and year): 1901 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer): House Work

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): born in Balt- Maryland

PARENTS

10 NAME OF FATHER: Stephen Wyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Betty Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Hospital Records M.T.H.

15 FILED JUL 25 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to July 21, 1922, that I last saw her alive on July 21, 1922, and that death occurred, on the date stated above, at 12.25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. In sputum, X-ray

(Signed) Frances X. Gallagher M. D.

7-21-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 25 1922

20 UNDERTAKER: Mrs Robert A Elliott ADDRESS 1722 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66234 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66234

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Trader

(a) RESIDENCE NO. 1617 Cole St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) March 15-22

7 AGE Years 10 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Trader.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Geo. Trader. (Address) 1617 Cole St.

15 Filed JUL 25 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1922

17 I HEREBY CERTIFY, That I attended deceased from 7-17, 1922, to 7-24, 1922, that I last saw h[illegible] alive on 7-24, 1922, and that death occurred, on the date stated above, at 2 10 P m.

The CAUSE OF DEATH* was as follows:

(a) Gastro Enteritis

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary) Intoxication

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) W C Caldwell M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL July 25 1922

20 UNDERTAKER Wallace Cook ADDRESS 502 E Wash

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Paul

D 66235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D 66235

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 742 W. Fayette St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren C. Paul.

(Residence in Baltimore: No. 742 W. Fayette St St.; yrs..... 6 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Don't Know (Month) (Day) 1 (Year)

7-AGE: 28 yrs..... mos..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE. (State or Country): Cambridge Md

PARENTS:

10-NAME OF FATHER. Charles Paul

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Lydia Jones

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Laughton

(Address) 5135 Park Heights

15- Filed JUL 25 1922 192 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 24 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held on..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration)..... yrs. dont Know mos..... ds.

CONTRIBUTORY (Secondary) dont Know

(Duration)..... yrs..... mos..... ds.

(Signed) H. H. Gorsuch M. D. (Coroner)

7.26 1922 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Cambridge Md.

19-PLACE OF BURIAL OR REMOVAL. Cambridge Md. DATE OF BURIAL. July 25 1922

20-UNDERTAKER. William Cook ADDRESS 502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 66236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S.V.HOSP.#56,

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 74 (WARD)

2-FULL NAME JAMES HANLON,

(a) RESIDENCE NO. U.S.V.Hosp.#56,Ft.McHenry,Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---Margaret V.Hanlon

6 DATE OF BIRTH (month, day, and year) ---Feby 28th 52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attendant

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer U.S.V.Hosp.#56-Ft.McHenry,Md

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Hanlon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant HOSPITAL RECORDS, (Address) U.S.V.HOSP.#56,Ft.McHenry,Md.

15 Filed JUL 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21/22 19

17 I HEREBY CERTIFY, That I attended deceased from May 3,1922 , 19 , to July 21 , 1922 ,

that I last saw him alive on July 21, , 19 22 ,

and that death occurred, on the date stated above, at 11:15 pm.

The CAUSE OF DEATH* was as follows:

MYOCARDITIS,CHRONIC (DECOMPENSATED)

(duration) - yrs. - mos. -- ds.

CONTRIBUTORY (Secondary) NEPHRITIS,CHR.(PARENCHYMATOUS)-

(duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical&Lab.Reports

(Signed) A.D.Luse M. D.

H.D.LUSE, Surgeon(R)

7/21/22 (Address) U.S.V.Hosp.#56, Ft.McHenry,Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL July 25 1922

20 UNDERTAKER Liston T. Fussellaugh ADDRESS 2620 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(McAleese) V

66237

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-D 66237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor, ST.: 10 WARD)

2-FULL NAME Annie McAleese

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Archibald McAleese

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary McMahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence, (Address) Little Sisters of the Poor

15 FILED JUL 25 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from No record 19 to 19

that I last saw her alive on July 23 1922,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July (Signed) F. A. Wiener, M. D.

24/22 19 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 26 — 1922
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-901 D 66238

CERTIFICATE OF DEATH.

D-66238

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Myrtle ave ST., 17 WARD)

2-FULL NAME Baby Bethel

(a) RESIDENCE NO. 406 Myrtle ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 7-17-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Lester Bethel

11 BIRTHPLACE OF FATHER (city or town) Greensboro (State or country) N. C

12 MAIDEN NAME OF MOTHER Mabel Anderson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Hospital Records (Address)

15 Filed JUL 25 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to July 24, 1922 that I last saw her alive on July 24, 1922 and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Finding

(Signed) J. Morris Reese M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL July 24 1922

20 UNDERTAKER Brown & Freland

ADDRESS 114 W Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66239

CERTIFICATE OF DEATH.

113 D 66239

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Dark ave ST., 18 WARD)

2-FULL NAME Vernon Brown

(a) RESIDENCE NO. 1125 Dark ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 29—1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X none

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) Balto City Md
(State or country)

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Laura Roane

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Grandmother
(Address) 1125 Dark ave

15 Filed JUL 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20. 1922. to July 23. 1922.
that I last saw him alive on July 23. 1922.
and that death occurred, on the date stated above, at 10, P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J F Munger, M. D.

, 19 (Address) 1002 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Auburn Cem — DATE OF BURIAL July 26 1922

20 UNDERTAKER Brown & Freeland — ADDRESS 1140 W. Saratoga St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66240

CERTIFICATE OF DEATH.

REGISTERED NO. 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1618 E. Madison St.; 1 Ward

2-FULL NAME Magnolia Ernestine Williams

(a) RESIDENCE. No. 1618 E Madison St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred √ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fannie Adams
(Address) 1618 E Madison St

15 Filed JUL 25 1922 E E Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to July 21, 1922, that I last saw h[illegible] alive on July 21, 1922, and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Nervous prostration

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Lived Here

Did an operation precede death? No Date of July 16

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Edw Short, M. D.

July 24, 1922 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Auburn Cem. DATE OF BURIAL: July 25 1922

20 UNDERTAKER: Mrs. J. G. Locks ADDRESS: 1302 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D 66241

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 66241

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH — Registered No. C 129

City of Baltimore (No. 4302 Fernhill Ave. St.) (28 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Harry C Fox

(Residence in Baltimore: No. 4302 Fernhill Ave St.: unknown yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If rite the word): married

6 DATE OF BIRTH: Oct (Month) 27 (Day), 1878 (Year)

7 AGE: 43 yrs. 8 mos. 23 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): 016

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: James or Fox

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Sharron

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Euphemia Fox
(Address) 4302 Fernhill Ave

15 Filed JUL 25 1922, 191 — ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 23 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1922 to July 23 1922
that I saw h-m alive on July 22, 1922
and that death occurred, on the date stated above, at 2330 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Interstitial Nephritis
From history - about 18 mo.
(Duration) yrs. mos. ds

Contributory (SECONDARY) Myocarditis (Broken compensation)
(Duration) yrs. 1 mos. 23 ds.

(Signed) Hallet S. Ablett M. D.
July 25/22, 191 (Address) 2220 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. — In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: July 25, 1922

20 UNDERTAKER: Chenoweth Son — ADDRESS: Gilmor

Spec.—1-10-21—M&T—1500 Bks.

D 66242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66242

CERTIFICATE OF DEATH.

15-31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. FORT McHENRY, MD. ST., WARD) 39

2-FULL NAME Charles Rogers

(a) RESIDENCE NO. 1824 Mullin St., Baltimore, Md. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. — How long in U. S., if of foreign birth? — yrs. — mos. — ds. —

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~HUSBAND~~ Ada Rogers

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 048

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) -- (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant (Address) Hospital records Ft. McHenry, Md.

15 Filed JUL 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1922.

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1922, to July 23, 1922, that I last saw him alive on July 23, 1922, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, Far Advanced & Active.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical reports

(Signed) H. M. Barker, M. D.
Surgeon (R)

7/23, 1922 (Address) U.S. Veterans Hosp. #56, Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL July 25, 1922

20 UNDERTAKER S. Levinson & Bro.

ADDRESS 1127 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 66243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66243

CERTIFICATE OF DEATH.

K 89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Morrow Hospital ST., 16 WARD)

2. FULL NAME Cornelius Connelly

(a) RESIDENCE NO. Morrow Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. 1 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 55 Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rigger 086

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant Seaman

(c) Name of employer U.S.S.B.

9 BIRTHPLACE (city or town) ..... (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Patients History

(Address) .....

15 Filed JUL 25 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/23 1922

17 I HEREBY CERTIFY, That I attended deceased from 6/1, 1922, to 7/23, 1922, that I last saw him alive on 7/23, 1922 and that death occurred, on the date stated above, at 10 8 m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) P.E. Echols, M. D.

7/24, 1922 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: July 25 1922

20 UNDERTAKER: A. Grinnon & Bro

ADDRESS 1217 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not luetic Negative.
No nephritis mouth
speaking of. Had
angina.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 66244 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1130 66244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No 1232 Glyndon Ave. ST.: 21 WARD)

2-FULL NAME Violet Griffin

(a) RESIDENCE. NO. 1232 Glyndon Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Anthony Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Naomi Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Mrs. Griffin
(Address) 1232 Glyndon Ave

15 Filed JUL 1922 19 ROGER T. [illegible] Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922, to July 24, 1922, that I last saw her alive on July 25, 1922, and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity Malnutrition

(duration) yrs. 4 mos. 23 ds.

CONTRIBUTORY (Secondary) Acute Gastro-Enteritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Poolakard, M. D.

7/25/22 (Address) 24 N. Fulton Ave'

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westen Cemetery	July 26 19
20 UNDERTAKER Frank A Fink	ADDRESS 114 Columbia Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

15-6330

D 66245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66245

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME John Robinson.

(a) RESIDENCE. NO. Peters Fla. ST., WARD Peters Fla.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1901.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Peters, Fla.

PARENTS

10 NAME OF FATHER J. R. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia.

12 MAIDEN NAME OF MOTHER Sallie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed 19 Robert F. Harrison. Registrar

JUL 25 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to July 23, 1922, that I last saw h.. alive on July 23, 1922, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic valvular disease

(duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Coutes Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gardner Florida

DATE OF BURIAL July 26 19

20 UNDERTAKER Joseph Andrews

ADDRESS 2211 Bus

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66246

CERTIFICATE OF DEATH.

113

D 66246

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Hanover ST. 23 WARD)

2-FULL NAME Andrew Mitsch

(a) RESIDENCE. No. 1613 Hanover ST 23 WARD

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. DO NOT WRITE IN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1, 1922

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
		5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Mitsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mamie Ulm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mamie Mitsch
(Address) 1613 Hanover St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1922, to July 24 1922, that I last saw h alive on July 23, 1922, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

a Cyto

Gastro Enteritis

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. F. Campbell M. D.

July 24, 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	July 26 1922

20 UNDERTAKER Wm J & Evan Sons ADDRESS 1418 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66247

CERTIFICATE OF DEATH.

113 D 66247

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE, (No. 1106 Carroll ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carolyn Wilma L. Lueken

(Residence in Baltimore: No. 1106 Carroll St. Life ....yrs. ....mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Mar (Month) 28 (Day), 1922 (Year)

7-AGE, ...yrs. 3 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Geo W Lueken

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mamie Knapp

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Lueken

(Address) 1106 Carroll St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

JUL 25 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 1922 to July 25 1922, that I saw her alive on July 25 1922, and that death occurred, on the date stated above, at 10 40a m.

The CAUSE OF DEATH* was as follows:

Coleo Colitis

.....

.....

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John G Schwemlein M. D.

July 25, 1922 (Address) 1112 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemtry

DATE OF BURIAL, July 27, 1922

20-UNDERTAKER Geo Leimbach & Son

ADDRESS July 26 '22 647 W Read St.

Spec.—1-10-21—M&T—1500 Bks.

D 66248

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-D 66248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Druid Hill Ave. ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Geo & Agnes Thomas

(a) RESIDENCE NO. 1423 Druid Hill Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Geo. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Agnes Sampson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Geo. Thomas (Address) 1423 Druid Hill Ave

15 Filed 1922, 19..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1922, to July 24, 1922

that I last saw him alive on July 24, 1922

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Immaturity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Delivery

(duration) yrs. mos. 1 da

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H Sampson M. D.

19 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 7/25 1922

20 UNDERTAKER: Jno. M. Johnson

ADDRESS 1234 Ething St.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66249

CERTIFICATE OF DEATH.

113 D 66249

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3311 First ave ST., No WARD)

2-FULL NAME Katherine L. Keeney

(a) RESIDENCE NO. 3311 First ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 26-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank W. Keeney

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Long.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Rose Keeney

(Address) 3311 First ave.

15 Filed 1922, 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20. , 1922, to July 24. , 1922, that I last saw her alive on July 24. , 1922, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Diarhoea Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. W. Jones M. D.

7/24, 1922 (Address) 1011 N. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL July 26 1922

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 66250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66250

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4515 Weitzel Ave ST., 7 WARD)

2-FULL NAME Augusta E. Burgemeister

(a) RESIDENCE NO. 4515 Weitzel Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph F. Burgemeister

6 DATE OF BIRTH (month, day, and year) Oct 6 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Scheffenbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Charlotte Weinard

13 BIRTHPLACE OF MOTHER (city or town) ..... Germany. (State or country)

14 Informant Paul Burgemeister
(Address) 4515 Weitzel Ave

15 Filed July 25 1922 Robert P. Harrison, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1922 to July 23 1922
that I last saw h alive on July 23 1922
and that death occurred, on the date stated above, at 1 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Probably Bulbar)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Burns, M. D.

July 24 1922 (Address) 4706 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL July 26 1922

20 UNDERTAKER Frank A. Fink ADDRESS 915 N Gay

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 66251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66251

CERTIFICATE OF DEATH.

6 45

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1721 Jefferson St ST., WARD)

2-FULL NAME Mary E: Wiessner

(a) RESIDENCE No. 1721 Jefferson St ST., 6R WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick C: Wiessner

6 DATE OF BIRTH (month, day, and year) July 22 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Bremer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kathern Werther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick C: Wiessner (Address) 1721 Jefferson St

15 Filed 1922 Robert P. Harrison, Registrar

JUL 25 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 5 1922, to July 24 1922, that I last saw h[illegible] alive on July 23 1922 and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Abdominal Sarcoma

(duration) — yrs. 7 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William F. Johnson, M. D.

7/25 1922 (Address) 2016 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem DATE OF BURIAL July 27 1922

20 UNDERTAKER J Ullrich ADDRESS 2008 Alliance

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestines first involved.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 66252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-081

D 66252

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 504 E Fort ave ST.: 24 WARD)

2-FULL NAME Baby Settlemoir

(a) RESIDENCE. No. 504 E. Fort ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-23-22

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lotus Settlemoir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill

12 MAIDEN NAME OF MOTHER Eva May Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lotus Settlemoir.
(Address) HOPKINS

15 Filed . 19 Registrar

Robert P. Harrison,
Burial Permit Clerk.

JUL 25 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from 7-23. , 1922, to 7-23 , 1922

that I last saw h im alive on 7-23 , 1922

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Premature birth
(4 months gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown M. D.

, 19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL JUL 25 1922 19

20 UNDERTAKER Commissioner Health.
R. WOODALL

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66253

CERTIFICATE OF DEATH.

38 D 66253

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. ..... ST., 16 WARD)

2-FULL NAME Mary Eliza Wilson

(a) RESIDENCE NO. 805 Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Do.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Bay View Hospital Baltimore, Md.

15 Filed JUL 25 1922, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to July 22, 1922

that I last saw h alive on July 22, 1922

and that death occurred, on the date stated above, at 10.00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lueticinfection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Serological findings

(Signed) H. J. Goldsmith M. D.

7/23/1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 25 1922, 19

20 UNDERTAKER Dept. of Health

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

14 B.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66254

CERTIFICATE OF DEATH.

D 66254

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) 22 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Johnson

(a) RESIDENCE. No. 809 Sharp st. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Johnson

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 870

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Easter Doggar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records (Address) U. T. H.

15 JUL 25 1922 19 Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922, to July 22, 1922, that I last saw him alive on July 22, 1922, and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dadaglucci M. D.

7-22, 1922 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JUL 26 1922 DATE OF BURIAL 19

UNIVERSITY OF MARYLAND.

20 UNDERTAKER Robert F. Harrison, Commissioner Health. ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66255

D 66255

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 7 WARD: 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anita Brown

(a) RESIDENCE. NO. Delta ST., WARD. Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaretta Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 25 1922 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24 1922 to July 25 1922; that I last saw h alive on July 25 1922 and that death occurred, on the date stated above, at 2.15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture.

(Signed) Horace G. Stewart, M. D.

(Address) Johns Hopkins Hospital

7/25, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa. DATE OF BURIAL July 25 1922

20 UNDERTAKER Joseph Ahrens ADDRESS 720 Bway

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman*, (*b*) *Grocery; (a) Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Only cause physician could give was haemophilia. Congenital Injury at birth

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66256

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.V.HOSPITAL#56, REGISTERED NO. 190

CITY OF BALTIMORE: (No. Ft.McHenry,Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MILTON MACKALL,

(a) RESIDENCE No. 1 Nunnery Lane, Catonsville,Md.
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 089

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) ---

12 MAIDEN NAME OF MOTHER ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ---

14 Informant HOSPITAL RECORDS,
(Address) Ft.McHenry,Md.

15 Filed JUL 25 1922, 19
Robert T. Harrison,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1919, to July 24, 1922,

that I last saw him alive on July 24, 1922,

and that death occurred, on the date stated above, at 9:35 p m.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound - Spinal cord

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Dilatation of stomach, acute.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? In France

Did an operation precede death? Yes Date of Oct. 1918

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Report

(Signed) H.D.Lusk, M. D.

7/24/22 (Address) SURGEON(R) U.S.V.Hosp.#56
Ft.McHenry,Md.

APA

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Port Republic Cahvert Co. DATE OF BURIAL July 25, 1922

20 UNDERTAKER S Linson & Bro ADDRESS 127 E. Balto St

Spec.—1-10-21—M&T—1500 Bks.

D 66257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lafferty

(a) RESIDENCE NO. 2242 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pa.

PARENTS

10 NAME OF FATHER Patrick H. Lafferty

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth R. Parker

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pa.

14 Informant Mrs. Rachel E. Duggan
(Address) 2242 W. Fayette Street

15 Filed JUL 25 1922, 19 Robert F. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24 - 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to July 24, 1922

that I last saw him alive on July 24, 1922

and that death occurred, on the date stated above, at 4 A, m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis.

Chronic endocarditis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Newton J. Parr, M. D.

7/27, 1922 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/26, 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66258

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Patapsco river off Masonville. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

18 ----------

2-FULL NAME..... Peter Trocki.

(Residence in Baltimore: No. 253 S. Regester St. St.; yrs....., mos....., ds.)

N. B.—THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. June 15th. 1888. 1.....
(Month) (Day) (Year)

7-AGE. 34 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Foreman street car repair gang
(b) General nature of industry, business, or establishment in which employed (or employer)..... U. Ry. & E. Co.

9-BIRTHPLACE, (State or Country). Poland.

PARENTS.

10-NAME OF FATHER. Peter Trocki.

11-BIRTHPLACE OF FATHER, (State or Country). Poland.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Janicki (brotherinlaw.)

(Address) 617 S. Patterson Park Ave.

15-

Filed 1922, 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23rd. 1922.
(Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
white in bathing.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) H. M. Bernard M. D.
(Coroner.)

July 25 192 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Holy Rosary July 26, 1922

20-UNDERTAKER. ADDRESS
John A Weber 1803 Bank St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66259

CERTIFICATE OF DEATH

D 66259

74-001

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 2739 W. North Ave. ST. 15 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Levi Moon

(Residence in Baltimore: No. 2739 W. North Ave. St.: 59 yrs. 1 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 12 (Day), 1863 (Year)

7 AGE: 59 yrs. 1 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Ass't U.S. Boiler
(b) General nature of industry, business, or establishment in which employed (or employer): Inspector D&C

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Robert Moon

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary A. Hutson

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sallie E. Moon (Wife)

(Address) 2739 W. North Ave.

15 Filed July 25 1922, 191

Robert P. Harrison, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 24 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922 to July 24 1922 that I saw h[illegible] alive on July 24 1922 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Chronic Nephritis. Hypertention (Duration) 5 yrs. — mos. — ds.

(Signed) Edgar C. Sandrock M. D.

July 25, 1922 (Address) 15 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: July 26, 1922

20 UNDERTAKER: John F. Zell — ADDRESS: 715 Light St

D 66260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66260

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Shore at Curtis Bay. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John William Riggins.

(Residence in Baltimore: No. Shore at Curtis Bay. St.; yrs. ---- mos. ---- 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. July 16th. 1922. (Month) (Day) (Year)

7-AGE. ---- yrs. ---- mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George Riggins.

11-BIRTHPLACE OF FATHER. (State or Country). Cambridge, Md.

12-MAIDEN NAME OF MOTHER. Annie Harman.

13-BIRTHPLACE OF MOTHER. (State or Country). Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Harman. (mother)

(Address) Shore at Curtis Bay.

15- Filed JUL 25 1922, 192.... Robert P. Harrison, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 24th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

July 25. 1922. (Address) 915 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Marley Church yard aaCo md. DATE OF BURIAL. July 26 1922

20-UNDERTAKER. John F Denny. ADDRESS 915 E. 5th st

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66261

CERTIFICATE OF DEATH.

129 D 66261

REGISTERED NO.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide Robinson

(a) RESIDENCE NO. Bay View Asylum ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred about 40 mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ----

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) Municipal Hospital.

15 JUL 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to July 23, 1922, that I last saw her alive on July 22, 1922, and that death occurred, on the date stated above, at 12:20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinically

(Signed) Clyde M. Neill, M. D.

7/24/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. | DATE OF BURIAL: July 26 22

20 UNDERTAKER: Samuel Dudley Sons | ADDRESS: 526 W. Lex.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66262

CERTIFICATE OF DEATH.

38 D 66262

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Berry

(a) RESIDENCE. NO. 17 W. Biddle st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rebecca Berry

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Berry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Burgess

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.C.H.

15 Filed JUL 26 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1922 to July 24, 1922, that I last saw him alive on July 24, 1922, and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Delaglicese M. D.

7-25-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. | DATE OF BURIAL July 27 22

20 UNDERTAKER Samuel Dudley | ADDRESS Md

Spec.—1-10-21—M&T—1500 Bks.

D 66263 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66263

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 534 N. Mechanic ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Welch

(a) RESIDENCE NO. 534 N. Mechanic ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Welch

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jerry Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Moore (Address) 534 N. Mechanic

15 Filed JUL 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to July 23, 1922, that I last saw him alive on July 23, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Duration Infinite.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) R. Carroll Edmunds M. D.

July 1922 (Address) 1524 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL July 25, 22

20 UNDERTAKER Samuel H. Dudley & Bro

ADDRESS 516

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66264

CERTIFICATE OF DEATH.

113 D 66264

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 813 (Burgundy) ST.: (21) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Reed.

(a) RESIDENCE. NO. 813 Burgundy ST. 21 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Howard Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eva Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Howard Reed

(Address) 813 Burgundy st

15 Filed JUL 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 — 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17 — 1922, to July 25 — 1922, that I last saw her alive on July 25 — 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 3 mos. 4 ds.

CONTRIBUTORY (Secondary) Ileo-Colitis (Acute)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Antignani, M. D.

, 19 (Address) 2942 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Der Even Lawn	July 6 1922
20 UNDERTAKER	ADDRESS
Mrs J E Evans & Sons	1428 St Charles

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66265

CERTIFICATE OF DEATH.

46

D 66265

REGISTERED No. C.

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. ..... St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Grace Kennard.

(Residence in Baltimore: No. Walbert Apts St.; ... yrs., ... mos. ... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7-AGE. 57 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at Home
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore and

PARENTS.

10-NAME OF FATHER. Jacob B. Waidner

11-BIRTHPLACE OF FATHER (State or Country) Baltimore md.

12-MAIDEN NAME OF MOTHER Caroline Eggleston

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward M. Kennard

(Address) 345 S. Webster ave

15- Filed JUL 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1922 (Year).

17- I HEREBY CERTIFY, That I attended deceased from July 11 1922, to July 25 1922, that I saw her alive on July 25 1922, and that death occurred, on the date stated above, at 8 20 a m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of cervix with metastasis

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) C E Duncan M. D.

7-25, 1922 (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, July 27, 1922

20-UNDERTAKER Chas. G. Black

ADDRESS 742 N. Fulton ave

(over)

Spec.—6-9-19—H. P. S.—1000 Bks.

Murr

D 66266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66266

CERTIFICATE OF DEATH.

REGISTERED No. 13

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Md. Gen Hospt ST. 23 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Murr

(a) RESIDENCE. No. 106 W West St ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months: 6 | Days: 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Murr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Agnes Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): [illegible] E. KRAUTER

15 Filed JUL 26 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25/22

17

I HEREBY CERTIFY, That I attended deceased from 7/14/22, 19, to 7/26/22, 19.

that I last saw him alive on 7/26/22, 19.

and that death occurred, on the date stated above, at 5 35 a m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms

(Signed) A Tompkins, M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: July 27 1922

20 UNDERTAKER: F. A. Krause & Co.

ADDRESS: 637 Lan[illegible]

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Marasmus due to gastro enteritis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66267

CERTIFICATE OF DEATH.

117 D 66267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial ST.: Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Thayer

(a) RESIDENCE. No. 3611 Fairview Avenue WARD. Forest Pk.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Thayer

6 DATE OF BIRTH (month, day, and year) May 6th 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wisconsin.

PARENTS

10 NAME OF FATHER John Otis Thayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Elizabeth Cevica

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mrs. Anna E. Thayer

(Address) 3611 Fairview Ave. Forest Pk

15 Filed JUL 26 1922 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 19 22

17

I HEREBY CERTIFY, That I attended deceased from July 25, 19 22, to July 26, 19 22

that I last saw him alive on July 26, 19 22,

and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis, ruptured

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Localized Peritonitis—Acute dilatation Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 25, 22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gordon L. Seagrave M. D.

7/26 19 22 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sheboygan Wis	July 27 22
20 UNDERTAKER	ADDRESS
Joseph J. Cook	1003 W. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15513 / 14268 — 60-B 66268

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Williams

(a) RESIDENCE. No. 1112 W. Hefferson St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Servant

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sem Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Beale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 26 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to July 23, 1922

that I last saw her alive on July 23, 1922

and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Course

(Signed) Francis R. Dieuaide, M. D.

July 24, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cr	July 26 19
20 UNDERTAKER Daniel Easton	ADDRESS 916 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Rutledge

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66269

CERTIFICATE OF DEATH.

14-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2238 E North av. ST.: 8 WARD)

2-FULL NAME Jesse C. Rutledge

(a) RESIDENCE. No. 2238 E North av ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life . ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): June 18 1840

7 AGE — Years: 82 — Months: 1 — Days: 6. — If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jesse Rutledge

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Pocock.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co. Md.

14 Informant: George Stine

(Address) 1302 N. Chester St

15 Filed JUL 26 1922 J. Wilkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1922

17

I HEREBY CERTIFY, That I attended deceased from July 23 1922 to July 24 1922 that I last saw him alive on July 24 1922 and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John W Sandeman, M. D.

, 19 (Address) 1714 E. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norrisville Cemetery Harford Co

DATE OF BURIAL: July 27 1922

20 UNDERTAKER: Wm T. Hartley

ADDRESS: 81 N Washington St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 66270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 76 WARD)

2-FULL NAME Sam Goodman

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Louis Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Einstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JUL 26 1922 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1922, to July 24, 1922, that I last saw him alive on July 24, 1922, and that death occurred, on the date stated above, at 1:35 P.M.

The CAUSE OF DEATH* was as follows:

Emphysema

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

7/25/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Beth Shalom Mem. Park — DATE OF BURIAL: July 26 1922

20 UNDERTAKER: Jack Lewis 1439 E. Balto. — ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lavitz

D 66271 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. 2006 E Fayette · 6 Ward) Registered No. C. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fauk, Lebik

(Residence in Baltimore: No. 2006 E Fayette St.; yrs. 34 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Unknown (Month) (Day) 1867 (Year)

7-AGE. 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION. (a) Trade, profession, or particular kind of work: Painter (b) General nature of industry, business, or establishment in which employed (or employer): 50

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Zelic Lavitz

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto. St.,

15- Filed JUL 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 26 192 2 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Stenosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) yrs. mos. 1 day

(Signed) C. C. Rhodes M. D.

(Witness) July 27th (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Herring Run	July 26th 19 22
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E. Balto. S

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66272

CERTIFICATE OF DEATH.

H/D 66272

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 255 S. Register ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kropp

(a) RESIDENCE NO. 255 S. Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Apr. 7- 1922

7 AGE — Years: | Months: 3 | Days: 22 | If LESS than 1 ~~day~~, ~~hrs~~ or ~~min~~.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): None.

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael Kropp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Margaret Makowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Machael Kropp

(Address): 255 S. Register St

15 Filed: JUL 25 1922 Received: ROBERT F. KRAUTHEIM Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1922

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 24, 1922, that I last saw h~~im~~er alive on July 22, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis Right Thigh

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): General Dipsis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 17/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William A Geraghty, M. D.

7/25, 1922 (Address) 203 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: July 26 1922

20 UNDERTAKER: H McFialkowski ADDRESS: 1108 Eastern ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dispensary case. Cause of deaths unknown.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66273

66273

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Bank. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bronislaw W. Ichnowski

(a) RESIDENCE NO. 1518 Bank. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Ichnowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Thomaskewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Ichnowski (Address) 1518 Bank. St

15 FILED JUL 26 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July - 24, 1922, to July 25, 1922, that I last saw h— alive on July 25, 1922, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion - Heat —

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? usual

(Signed) M. P. O'Brien M. D.

, 19 (Address) 125 S Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL 7/27 1922

20 UNDERTAKER Wm Ficklowski ADDRESS 1118 Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66274

CERTIFICATE OF DEATH.

113 D 66274

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 318 S Gilmor ST., 19 (WARD)

2-FULL NAME Alfred J Dimler

(a) RESIDENCE NO. 318 S Gilmor ST., 19 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 17 21

7 AGE — Years: 10 Months: Days: 6 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm J Dimler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind Balto

12 MAIDEN NAME OF MOTHER: Elenor Kroyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Balto

14 Informant: Father

(Address): 318 S Gilmor

Filed JUL 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/23/1922

17 I HEREBY CERTIFY, That I attended deceased from 7/21, 1922, to 7/23, 1922, that I last saw h— alive on 7/23, 1922, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Duration

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Brain, M. D.

, 19 (Address) 1727 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salem Lutheran Cemetary Catonsville — DATE OF BURIAL: July 26th 1922

20 UNDERTAKER: A Jones — ADDRESS: 217 S Stricker St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

66275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 66275

1-PLACE OF DEATH Garrett Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey St. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Smallwood.

(a) RESIDENCE NO. 107 S. Payson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 24 - 1910

7 AGE: Years 12 Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard Co. Md

PARENTS

10 NAME OF FATHER: Joseph L. Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co, Md

12 MAIDEN NAME OF MOTHER: Gertrude L. Downes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Montgomery Co Md

14 Informant: Joseph L. Smallwood (Address) 107 S. Payson St.

15 Filed JUL 26 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1922, to July 25, 1922, that I last saw him alive on July 25, 1922, and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis - general.

(duration) 12 hrs. yrs. mos ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 107 S. Payson St

Did an operation precede death? Yes Date of July 25, 22.

Was there an autopsy? No.

What test confirmed diagnosis? Laparotomy + appendectomy

(Signed) Chas. L Mannell M. D.

, 19 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Olivet DATE OF BURIAL: July 28 1922

20 UNDERTAKER: George L. Lohmeyer ADDRESS: 1701 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66276

CERTIFICATE OF DEATH.

100-901 66276

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 N. Calhoun ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bennie L. Driver

(Residence in Baltimore: No. 1015 N. Calhoun St.; 1 yrs., 7 mos. 20 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, November 3, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none yet.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Lewis Driver

11-BIRTHPLACE OF FATHER (State or Country), Gloucester Co. Va

12-MAIDEN NAME OF MOTHER Ruth Bluford

13-BIRTHPLACE OF MOTHER (State or Country), Gloucester Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) 1015 N. Calhoun St.

15- JUL 26 1922

Filed ....., 191.... J. H. Wilms Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1922, to July 26 1922, that I saw him alive on July 26 1922, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank C. Saunders M. D.

July 26, 1922. (Address) 1123 N. Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem DATE OF BURIAL. 7-28, 1922

20-UNDERTAKER Saml. H. Cloud & Son ADDRESS 1400 Madison

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66277

CERTIFICATE OF DEATH.

1122 66277

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Whitehall's Shoe-Curtis Bay ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin M. Priller

(Residence in Baltimore: No. Whitehall's Shoe-Curtis Bay St.: ....yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 8th, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None yet
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Martin J. Priller

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mamie Fantacla

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin J. Priller

(Address) Whitehall's Shoe-Curtis Bay

15- JUL 26 1922

Filed ....., 191.... J. Welsh Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21st, 1922, to July 25 1922, that I saw h-- alive on July 24 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) William A. Leath M. D.

July 25, 1922 (Address) 5116 Pennington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross U. A. C.

DATE OF BURIAL, July 26, 1922

20-UNDERTAKER P. Augustine G. Flynn

ADDRESS 1011 Light St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66278

D 66278

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1007 Hanover St. ST., 24 WARD)

2-FULL NAME Martin Gayo

(a) RESIDENCE No. 1370 Andre St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Gayo.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Tasch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs M Gayo (Address) 1370 Andre Street

15 Filed JUL 26 1922, 19 H Webb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 25, 1922, that I last saw him alive on July 24, 1922 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs mos 10 ds.

CONTRIBUTORY (Secondary) Convulsions--Acidosis

(duration) yrs mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw C. Colohan, M. D.

7/25/1922 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL July 27 1922

20 UNDERTAKER Maynard A Flynn ADDRESS 14 N Eutaw St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item & information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

155692. HEALTH DEPARTMENT—CITY OF BALTIMORE D 66279

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Anatomical Board

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (St.:) (Ward) 14

2-FULL NAME Walter Lee

(a) RESIDENCE. No. 1401 Division St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years ? Months 22. Days ? If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: JOHNS HOPKINS HOSPITAL.

(Address): JOHNS HOPKINS HOSPITAL.

15 Filed JUL 26 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 4 1922, to July 22 1922, that I last saw him alive on July 22 1922, and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at 1401 Division St

Did an operation precede death? Yes Date of July 22, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wakefield W. Firor, M. D.

7/23, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUL 26 1922 19

20 UNDERTAKER: Commissioner of Health, By Wm. F. Woodall

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

157097.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 66280

REGISTERED NO.

1-PLACE OF DEATH L 66280

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brooks

(a) RESIDENCE. No. 9 N. Plum Alley City WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 5 1922.

7 AGE: Years ? Months ? Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: John Brooks.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va.

12 MAIDEN NAME OF MOTHER: Mary Robinson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 26 1922 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 19, 1922, that I last saw h[illegible] alive on July 19, 1922, and that death occurred, on the date stated above, at 1220 A.m.

The CAUSE OF DEATH* was as follows:

Early Hereditary Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wt. 2 lb. 13 oz

(Signed) Horace G. Stewart, M. D.

7/19, 1922 (Address) Johns Hopkins Hosp-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL DATE OF BURIAL JUL 2[illegible] 19

20 UNDERTAKER (Commissioner Health,) ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Eks.

18-7216. 66281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66281

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL (St.) 25 (WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Pugh.

(a) RESIDENCE. No. 1 11th St. (St.) Fairfield, Md. (WARD.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced (or) WIFE of: Alive Pugh (Mother)

6 DATE OF BIRTH (month, day, and year) June 16, 1922

7 AGE — Years: — Months: 1 Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Turner Pugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER Alice Barber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant JOHNS HOPKINS HOSPITAL. Record

(Address)

15 Filed JUL 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to July 21, 1922, that I last saw him alive on July 21, 1922, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wright

(Signed) Horace G. Stewart, M. D.

7/22, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUL 26 1922

20 UNDERTAKER: Commissioner Health.

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137099
66282

161-001
D 66282

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noreen Wallis

(a) RESIDENCE. No. 837 Holland ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 4-1922

7 AGE — Years: — Months: 1 Days: 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: JOHNS HOPKINS HOSPITAL. (Address): JOHNS HOPKINS HOSPITAL

15 Filed JUL 26 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 1922, to July 21st, 1922, that I last saw h[illegible] alive on July 21st, 1922, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Weight

(Signed) Horace G. Steuart M. D.

7/22, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUL 26 1922

20 UNDERTAKER: Undertakers' Board, per Wm. R. Woodall

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-D 66283

D 66283

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2420 Oak St St. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Scarles

(a) RESIDENCE. No. 2420 Oak St St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	aa	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		14 hrs July		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nn

(b) General nature of industry, business, or establishment in which employed (or employer) nn

(c) Name of employer nn

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Solomon Scarles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Ella Bell Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant

(Address)

15 Filed JUL 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17

I HEREBY CERTIFY, That I attended deceased from July 25 1922, to July 25 19

that I last saw h[illegible] alive on July 25 1922,

and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Physical Condition of Mother and premature Birth

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Physical condition of Mother (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? nn

Did an operation precede death? nn Date of

Was there an autopsy? nn

What test confirmed diagnosis? Physical Exam

(Signed) Geo Hall, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

HOPKINS HOSPITAL [illegible] 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66284

CERTIFICATE OF DEATH.

164 D 66284

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Bay View Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Loughlin

(Residence in Baltimore: No. Not known St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, Not known, 1 ..... (Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUL 26 1922 ROBERT R. KRAUTER
Filed ..... 191 ..... Registrar.
Morgue Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH July 24, 1922
..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypo. Pneumonia

..... (Duration) ..... yrs. ..... mos. 1 wk

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Claude Blades M.D.
(Coroner.)

July 26 1922 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. ..... 19 ...

20-UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

UNIVERSITY OF MARYLAND.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66285

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2719 Oak st ST.: 12 WARD)

2-FULL NAME Mary K. Kerr

(a) RESIDENCE. NO. 2719 Oak st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 21 1874

7 AGE: Years 48. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Francis J. Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Clara L. Niemeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Jos. J. Kerr 136 N. Fulton ave

15 Filed JUL 26 1922 ROBERT H. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Feby 4 1921 to July 23 1922 that I last saw h er alive on July 23 1922 and that death occurred, on the date stated above at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 1 yrs. 4 mos. 20 ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirm diagnosis? Physical Signs

(Signed) Caleb N Bethea M. D.

July 25 1922 (Address) 100 S. Potteron Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer DATE OF BURIAL: July 27 1922

20 UNDERTAKER: Jos. J. Kerr ADDRESS: 136 N. Fulton

Perry Miles

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66286

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1114 Hasselbergs ST.; 23 WARD)

2-FULL NAME Jerry Miles

(a) RESIDENCE. No. 1114 Hasselberger ct ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Jack Collins
(Address) 1114 Hasselbergs ct

15 JUL 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/24/1922

17 I HEREBY CERTIFY, That I attended deceased from 7/10/1922, to 7/24/1922, that I last saw ... alive on 7/23/1922, and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) about 1 mos. ds.,

CONTRIBUTORY (Secondary) Interstitial nephritis

(Duration) about 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. Jerry Miles, M. D.

19 (Address) 908 Stiles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct

DATE OF BURIAL: July 27 1922

20 UNDERTAKER: J. L. Brown & Son

ADDRESS: 108 N. Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-2-19 H. P. Co.—1000 Bks.

D 66287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66287

X 101-001

CERTIFICATE OF DEATH.

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. University Hospital ST. 4 WARD

2-FULL NAME Lucy Jenkins

(a) RESIDENCE. No. Arundel, Va ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced (or) WIFE of Clarence N. Jenkins

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Hannibal Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Jennie Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records.
(Address)

15 Filed JUL 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14 1922 to July 25 1922 that I last saw h[illegible] alive on July 25 1922 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) A B Jones

July 25. 1922 Address Univ. Hospital Balto City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rugg's Dale Wharf Va DATE OF BURIAL: July 26 1922

20 UNDERTAKER: Edward Ruggold ADDRESS: 1468 Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 D 66288

REGISTERED NO.

1-PLACE OF DEATH Garrett Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27 N Carey Street . ST. 21 WARD)

2-FULL NAME Hilda Marie Myers.

(a) RESIDENCE No. 805 W. Pratt ST. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23' 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		2 mos	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Alice Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Alice [redacted] Myers

(Address) 13th Street Roland Park

15 JUL 26 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1922

17

I HEREBY CERTIFY, That I attended deceased from July 22 . 1922 . to July 26 . 1922.

that I last saw her alive on July 25 . 1922.

and that death occurred, on the date stated above, at 6.50 p m.

The CAUSE OF DEATH* was as follows:

Dysentery - Bacillary.

(duration) yrs mos 14 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs 2 mos ds.

18 Where was disease contracted if not at place of death? 805 W. Pratt St

Did an operation precede death? No Date of

Was there an autopsy? No Clinical course & Stool

What test confirmed diagnosis?

(Signed) Chas. L. Warner M. D.

, 19 (Address) 700 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Ant — DATE OF BURIAL: July 27 1922

20 UNDERTAKER: Jos Joerderson Son — ADDRESS: 217 S Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66289

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 949 Bennett Place ST.: 18 (WARD)

2-FULL NAME Philomena Limbaum

(a) RESIDENCE. NO. 949 Bennett Place ST.: WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 3. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John G. Emmott

11 BIRTHPLACE OF FATHER (city or town) Baden
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lockenlen

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country) U.S.A.

14 Informant John G. Emmott
(Address) 2958 W. Lexington St

15 [illegible] 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1922, to July 24, 1922, that I last saw h[illegible] alive on July 24, 1922, and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows: Chronic Organic Heart Disease (Mitral Insufficiency)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? ...

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown M. D.

(Address) 1837 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: July 21st 1922

20 UNDERTAKER: H. Brauns Son

ADDRESS 517 N. Schroeder St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 26 1922

(Leitch)

D 66290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Foster Ave & Clinton St. Ward) 196

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Allen Leitch

(Residence in Baltimore: No. 1916 Edmondson Ave. St.; yrs. (15) mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. October (Month) 1st (Day) 1889 (Year)

7-AGE 33 yrs. 10 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): Con. G. & E. Co.

9-BIRTHPLACE. (State or Country). Friendship-A A Co Maryland

PARENTS.

10-NAME OF FATHER. Joseph Aseton Leitch

11-BIRTHPLACE OF FATHER. (State or Country) Friendship A A Co Md.

12-MAIDEN NAME OF MOTHER. Emma Augusta Howard

13-BIRTHPLACE OF MOTHER. (State or Country). A A Co. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard M. Dashiell

(Address) 1916 Edmondson Ave

15- Jul 26 1922 Robert F. Harrison, 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 25-22 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted

(Duration) ..... yrs. at once mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John R. Norton M. D. (Coroner.)

July 25-22 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Burns, Ac.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park. DATE OF BURIAL. July 28 19..

20-UNDERTAKER. Chas. E. Foard ADDRESS 802 Madison Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66291

CERTIFICATE OF DEATH.

D 66291

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 827 Powers St. (ST.) 13 (WARD)

2-FULL NAME Alexius Morris

(a) RESIDENCE NO. 827 Powers St. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Lida Talbott Morris

6 DATE OF BIRTH (month, day, and year): May 18-1847

7 AGE — Years: 75 — Months: 2 — Days: 6 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 2 years

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: Louis Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Jessie A. Morris

(Address): 827 Powers St.

15 Filed 7/26 1922 .19 Registrar

Robert P. Harrison,

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1922

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1922, to July 24, 1922,

that I last saw him alive on July 23, 1922,

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 827 Powers St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) [illegible], M. D.

7/26, 1922 (Address) 342 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leisburg M.E. Cem. (Balto. Co.)

DATE OF BURIAL: July 27 1922

20 UNDERTAKER: Horace F. Burgee

ADDRESS: 363 Fallsway

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66292

CERTIFICATE OF DEATH.

D 66292

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842-3rd Ave-Fairfield ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie O Cooper

(Residence in Baltimore: No. 842-3rd Ave-Fairfield — St.: 3 yrs., 4 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

JUL 26 1922

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: April (Month) 27 (Day), 1886 (Year)

7-AGE: 36 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): South Carolina

PARENTS.

10-NAME OF FATHER: Robert Cooper

11-BIRTHPLACE OF FATHER (State or Country): South Carolina

12-MAIDEN NAME OF MOTHER: Hattie Simmons

13-BIRTHPLACE OF MOTHER (State or Country): South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie Cooper

(Address) Fairfield Md.

15-

Filed JUL 26 1922, 191

Registrar.

Robert E. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1922, to July 25 1922, that I saw her alive on July 25 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) William D Scott M. D.

July 26, 1922 (Address) 842 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL, July 26, 1922

20-UNDERTAKER: Robert E Williams — ADDRESS 1106 Ashland ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66293

D 66293

CERTIFICATE OF DEATH.

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1109 Scott (St.:) 21 (Ward)

2-FULL NAME Henry Carl Musselman

(a) RESIDENCE. No. 1101 Scott St., 21 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Kally Musselman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio Dayton

12 MAIDEN NAME OF MOTHER Hilda Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Kally Musselman
(Address) 1101 Scott St

15 Robert P. Harrison, Registrar

Burial Permit Clark.

JUL 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to July 25, 1922, that I last saw h— alive on July 25, 1922, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Cent. Hem

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis?

(Signed) Edw Gunnison M. D.

7/26 1922 (Address) 507 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	July 27 1922
20 UNDERTAKER	ADDRESS
Geo Lewis Sons	697 N Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66294

CERTIFICATE OF DEATH.

X 113 D 66294

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Durham ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jozef Dobrecki

(Residence in Baltimore: No. 414 S. Durham St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, January 24, 1921.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 6 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Sparrows Point Bge mill Balto Co Md

PARENTS.

10-NAME OF FATHER, Anton Dobrecki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Rosalie Babczyk

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anton Dobrecki

(Address) 414 S. Durham

15-

Filed....., 191.....

Registrar.

26 1922 Robert F. Harrison, Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1922, to July 26 1922, that I saw him alive on July 26 1922, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Convulsions

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Ind. Gastritis

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) H. Edwards Ricketts M. D.

July 26, 1922 (Address) 722 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	July 27, 1922
20-UNDERTAKER	**ADDRESS**
John M. Fisher	1803 Bank

Remarks

Cause from Balto. Co. Interstitial nephritis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

D 66295 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 66295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Stockton Baltimore St. 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Enoch Jones

(Residence in Baltimore: No. 1326 Lemmon St., 73 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. April (Month) 9 (Day) 1850 (Year)

7-AGE. 72 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) E D Kenny's

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Jones Jones

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Courtney Jones

(Address) 913 McCulloh St

15- Filed JUL 26 1922, 192.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Prostration Sudden

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenlon M. D. (Coroner.)

July 25 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	July 28 1922

20-UNDERTAKER. Brown Fred and Schenker ADDRESS 1140

U.S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66296

CERTIFICATE OF DEATH.

179

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1217 Rebecca St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Stanley

(Residence in Baltimore: No. 1217 Rebecca St., ...yrs., ...mos., ...ds.)

N-B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	widower

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1881 (Year)

7-AGE. 41 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER, Joseph Stanley

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie Henry

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Stanley

(Address) 1628 Pierce st

15- Filed ... 192 ... Robert P. Harrison, Registrar.

JUL 26 1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic nephritis Interstitial

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) James M. Preston M. D. (Coroner)

July 25 1922 (Address) 700 E. Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	July 28 1922

20-UNDERTAKER, Brown & Freeland & Schroder ADDRESS 114 W. Saratoga St.

D 66297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66297
Registered No. C

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 Sarah Ann St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos Anderson

(Residence in Baltimore: No. 1102 Sarah Ann St. 30 St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-CONDITION (Single, Married, Widowed, or Divorced. (Write the word.)): Widowed

6-DATE OF BIRTH: March (Month) 7 (Day) 1872 (Year)

7-AGE: 50 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer): D.B.

9-BIRTHPLACE (State or Country): Md

PARENTS.

10-NAME OF FATHER: Harry Anderson

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Sarah J. Green

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Anderson

(Address) 2203 N. Sargent St.

15-
Filed JUL 27 1922 19 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 24 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Ac Indigestion
(Toxic Diet)

(Duration) yrs. mos. 1 hr. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 12 hr. ds.

(Signed) C. C. Lodge M. D.

July 26 '22 (Coroner)

(Address) 143 E. Eager

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn DATE OF BURIAL: 7-27-22

20-UNDERTAKER: Sam'l W. Chase Sons ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66298 D 66298

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 120 Scott ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V Clarke

(a) RESIDENCE NO. 120 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: asaph m clarke

6 DATE OF BIRTH (month, day, and year): Feb 4 1874

7 AGE: Years 48 | Months 5 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Wm M Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Asaph M Clarke

(Address) 120 Scott st

15 Filed JUL 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to July 26, 1922

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) High Blood pressure

(Duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hubbard Dorsey M. D.

, 19 (Address) 1227 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: July 29 1922

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light st

Spec.—1-10-21—M&T—1500 Bks.

D 66299 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66299

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1831 N.Caroline ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A.Welden

(a) RESIDENCE NO. 1831 N.Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND (or) WIFE of Michael J.Welden

6 DATE OF BIRTH (month, day, and year) Aug.4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm.J.Graham

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice A.Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Mrs.Alice A.Graham

(Address) 1508 E.Federal St.

15 Filed JUL 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 25, 1922

that I last saw her alive on July 25, 1922

and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grimshaw M. D.

7/26 1922 (Address) 814 Cath

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL July 28 1922

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66300

CERTIFICATE OF DEATH.

1919 Registered No. C.....

D 66300

1-PLACE OF DEATH

City of BALTIMORE: (No. 1519 W Franklin St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Owen

(Residence in Baltimore: No. 1519 W Franklin St.; yrs. 57 mos. 4 ds. 27)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: February 28th (Month) (Day) 1871 (Year)

7-AGE: 57 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: William Dempsey

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Catherine Gormley

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Trudy Owen

(Address) 1519 W Franklin St

15-JUL 27 1922 Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

(Coroner)

July 26 1922 (Address) 1143 N Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: July 28 1922

20-UNDERTAKER: [illegible] ADDRESS: 901 Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66301

CERTIFICATE OF DEATH.

114 D 66301

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 W. Saratoga ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brown

(a) RESIDENCE. NO. 1514 W. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	~~Widowed~~ ~~Divorced~~

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Eliza Brown

6 DATE OF BIRTH (month, day, and year) Oct. 15- 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Day labor

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): West Point Md.

PARENTS

10 NAME OF FATHER: Herschel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Richard Brown 1514 W. Saratoga St.

15 JUL 27 1922 ROBERT R. KRAUTER. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24- 1922

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to July 24-, 1922, that I last saw h~~im~~ alive on July 23-, 1922, and that death occurred, on the date stated above, at 6-15 A. m.

The CAUSE OF DEATH* was as follows:

Impaction of bowels & gastritis.

(duration) — yrs. — mos. 5- ds.

CONTRIBUTORY (Secondary) Gastro-enterologic & gastritis (duration) — yrs. one mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	July 27 d. 192

20 UNDERTAKER A. Jones ADDRESS 29 S. Stricker St.

Spec. 13-21 – M&T – 1500 Bks.

D 66302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66302

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 Brehms Lane ST. 8 WARD)

2-FULL NAME George Edward Hetterick

(a) RESIDENCE NO. 9 Brehms Lane ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): May 6th 1922

7 AGE — Years | 2 Months | 19 Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hetterick

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Daisy Farrar

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant John Hetterick (Address) 9 Brehms Lane

15 Filed JUL 21 1922 19 ROBERT R. KNAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17

I HEREBY CERTIFY, That I attended deceased from July 18 1922 to July 25 1922, that I last saw h[illegible] alive on July 25 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

July 24th 1922 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jerusalem Cemetery — DATE OF BURIAL: July 27 22

20 UNDERTAKER: Fredk. Leasalmon Sons — ADDRESS: Fullerton Md

Ide

D 66303 HEALTH DEPARTMENT—CITY OF BALTIMORE 181-001 D 66303

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 W. Fayette St. St., 18 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chisham H Ide

(Residence in Baltimore: No. 815 W. Fayette St. St.; yrs. 58 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Sigle

6-DATE OF BIRTH: Dont Know (Month) (Day) 1..... (Year)

7-AGE: 64 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont Kno

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Steinbrecher

(Address) 815 W. Fayette St

15- JUL 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 26 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or)~~ (Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or)~~ (Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Inhalation of illuminating Gas-

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Probably Accidental

(Duration) yrs. mos. ds.

(Signed) W. H. Forsyth M. D. (Coroner)

7-27 1922 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem DATE OF BURIAL: July 28 1922

20-UNDERTAKER: William Cook ADDRESS: 502 E Northern

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66304

CERTIFICATE OF DEATH.

103 D 66304

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 917 Bevan St., St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Seidling. (St.; yrs. 46 mos. 8 ds. 18)

(Residence in Baltimore: No. 917 Bevan St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. November 8th. 1875. (Month) (Day) (Year)

7-AGE. 46 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Henry Seidling.

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Sophia Beck.

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Seidling. (brother)

(Address) 917 Bevan St.

15- FILED JUL 27 1922 ROBERT R. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 26th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dementia.

Hypostatic congestion of the lungs.

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Otto T. Reinhardt M. D. (Coroner)

July 27 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
H W Oliver Cem. July 28 1922

20-UNDERTAKER. William Cook. ADDRESS 501 E. North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

98 D 66305

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 N. Robinson ST., 1 WARD)

2-FULL NAME Ella B. Hanna

(a) RESIDENCE No. 606 N Robinson ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James V. Hanna

6 DATE OF BIRTH (month, day, and year) Nov. 22. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Saml. McCurdy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant James V. Hanna
(Address) 606 N Robinson St

15 JUL 27 1922 S E Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1 1922 to July 25 1922

that I last saw him alive on July 24 1922

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) J. Mc... M. D.

July 27 19 22 (Address) 800 N Mad...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 29 1922

20 UNDERTAKER Geo W. Fuck Son — ADDRESS 811 N Wolfe

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Venzy)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

157370 Med D 66306

47 D 66306

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tillie Venzy

(a) RESIDENCE. NO. 1005 Granby St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: I. Venzy

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE — Years: 58 — Months: ? — Days: ? — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed: JUL 27 1922 19 J. H. Mehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to July 26, 1922, that I last saw her alive on July 26, 1922, and that death occurred, on the date stated above, at 1 57 P.m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Cancer of Lung (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July-1915

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. Sidney Burwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 7/27 1922

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balt

FILL IN ALL BLANKS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66307 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66307

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigmund Gristein

(a) RESIDENCE NO. 2039 Eagle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE Hr.

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Fanny Gristein

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 68 yrs. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinsmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Rose Gristein

(Address) 2039 Eagle St.

15 Filed JUL 27 1922 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-29 1922 to 7-27 1922

that I last saw him alive on 7-27 1922

and that death occurred, on the date stated above, at 8 a.m. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) General intestinal Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-29-22

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray & Clinical

(Signed) L.C. Cardwell, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Wash Rd DATE OF BURIAL 7-27 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

+ D 66308

HEALTH DEPARTMENT—CITY OF BALTIMORE

98 D 66308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 27 (WARD)

2-FULL NAME Henry Miller

(a) RESIDENCE. No. 110 Graymore Road, ST., Hamilton, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22-56

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed JUL 27 1922, 19 H Helm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to July 25, 1922, that I last saw h[illegible] alive on July 25, 1922, and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis; mitral insufficiency

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Warfield M. Firor, M. D.

7/25, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	July 27 1922
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

INSTRUCTIONS—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66309

CERTIFICATE OF DEATH.

113 66309

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Catherine ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M Emey

(a) RESIDENCE. No. 302 Catherine St. ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 21-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Grover C Emey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Augusta Knopf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Grover C Emey
(Address) 302 Catherine St

15 Filed JUL 27 1922 J E Welsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1922, to July 25, 1922, that I last saw her alive on July 25, 1922, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Dysentery (duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical signs

(Signed) Eva L Hessels, M. D.

July 27, 1922 (Address) 2562 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 27 1922

20 UNDERTAKER George H Schwab ADDRESS 1101 Pratt. Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dysentery due to Gastro intestinal trouble

Spec.—1-10-21—M&T—1500 Bks.

D66310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D66310

CERTIFICATE OF DEATH.

6 47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 E Baltimore ST., 6 WARD)

2-FULL NAME Mary E. Strott

(a) RESIDENCE NO. 2816 E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. 28 ds. How long in U. S., if of foreign birth? Yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: John J. Strott

6 DATE OF BIRTH (month, day, and year): June 28 1862

7 AGE — Years: 60 — Months: — — Days: 28 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Richard Rountree

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rebecca Browning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Son John J. Strott

(Address) 2816 E Balto St.

15 Filed JUL 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1921 to July 26 1922

that I last saw h[illegible] alive on July 26 1922

and that death occurred, on the date stated above, at 12-25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(duration) yrs. 16 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo S Silyacks, M. D.

, 19 (Address) 2818 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: July 28 1922

20 UNDERTAKER: Henry Kouck & Son — ADDRESS: 1301 E Eag[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66311 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66311

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.) (WARD) 15

2-FULL NAME Fanny Ferguson

(a) RESIDENCE. NO. 410 Forrest Park Road WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: For Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Ferguson

6 DATE OF BIRTH (month, day, and year): Jan 2, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William C. Dr Vall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sabra Kendall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hosp Record

15 Filed . 19 ROBERT H. KNAUER, Registrar

JUL 27 1922. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to July 27, 1922, that I last saw her alive on July 27, 1922, and that death occurred, on the date stated above, at 2:50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma, intestine

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) yrs. mos. 3½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gordon L. Seagrave, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 29 19
20 UNDERTAKER: Henry Jenkins Sons	ADDRESS: Orland & Madison Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66312

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.; 10 WARD)

2-FULL NAME George Streb.

(a) RESIDENCE. No. 1001 Ensor St. City ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... dy. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Elizabeth Streb

6 DATE OF BIRTH (month, day, and year) March 7 1868.

7 AGE: Years 54; Months 3; Days 29; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: City Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Conrad Streb.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1922, to July 26, 1922, that I last saw him alive on July 26, 1922, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 3 yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? 1001 Ensor St.

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis?

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 29 1922

20 UNDERTAKER: Henry Hood & Son — ADDRESS: 1301 E. Eager St

information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66313

CERTIFICATE OF DEATH.

D 66313

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Joseph Young

(Residence in Baltimore: No. 1226 Ashland Ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. May (Month) 1 (Day) ..... (Year)

7-AGE. 64 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Horse Breeder
(b) General nature of Industry, business, or establishment in which employed (or employer). 050

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Ignatius Young

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER. (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Robert S. Young

(Address) 1226 Ashland Ave

15-

JUL 27 1922 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Accident

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lyle Coulson M. D.
(Coroner)

July 26 1922 (Address) 423 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemy DATE OF BURIAL. July 29 19 22

20-UNDERTAKER. Henry Storck Son ADDRESS 1501 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66314

CERTIFICATE OF DEATH.

D 66314

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1019 N. Gardenier ST., 9 WARD)

2-FULL NAME George Ramming

(a) RESIDENCE NO. 1769 Abbottston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. Lp mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Ramming

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Retina Schlaer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr. John Ramming
(Address) 1769 Abbottston St

15 Filed JUL 27 1922 ROBERT R. KRAETER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 26 19 22 to July 26 19 22
that I last saw him alive on July 26 19 22
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) Robert A. Magruder, M. D.

19 (Address) 1501 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemy	July 28 19 22
20 UNDERTAKER	ADDRESS
Henry Storch Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66315

CERTIFICATE OF DEATH.

1000 D 66315

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 Cliftview Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Charles Trust

(Residence in Baltimore: No. 1636 Cliftview Ave St.; ....yrs., ...mos. 10 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 17 (Day), 1922 (Year)

7-AGE, ...yrs. ....mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Harry Trust

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alverta Trosnell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry H. Trust

(Address) 1636 Cliftview Ave

15-

Filed ..... 191 ROBERT R. KRAMER Registrar.

JUL 27 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1922, to July 27 1922, that I saw him alive on July 27 1922, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) Geo. C. Lang M. D.

July 27, 1922 (Address) 27 Hartford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Co

DATE OF BURIAL, 7-29, 1922

20-UNDERTAKER Wm Cook

ADDRESS 501 Nall

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66316

CERTIFICATE OF DEATH.

3 / D 66316

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST.. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Johnson

(a) RESIDENCE. NO. City Mission, Eastern Av ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Hospital Records (Address) U. T. H.

15 Filed JUL 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to July 24, 1922, that I last saw him alive on July 24, 1922, and that death occurred, on the date stated above, at 8.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dalyhaen M. D.

7-24-22 (Address) Municipal Tuberculosis Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND DATE OF BURIAL: JUL 27 1922

20 UNDERTAKER: Bureau of Vital Statistics. ADDRESS

N. B.—WHITE PLANET, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66317

31

CERTIFICATE OF DEATH.

D 66317

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Davis

(a) RESIDENCE. NO. 400 N. Calvert st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Len Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Minnie Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Records
(Address) U.T.H.

15 Filed JUL 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1922, to July 24, 1922, that I last saw him alive on July 24, 1922, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L. Badgley M. D.

7-24-1922 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 27 1922

20 UNDERTAKER Bureau of Municipal Health,

ADDRESS

N. B.—WHILE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

~~STILLBIRTH~~ 161

1001

D 66318

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 6th ST., N (WARD)

2-FULL NAME Helena Florian

(a) RESIDENCE NO. 1108 6th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1922

7 AGE — Years: 0 — Months: 0 — Days: 0 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Max Florian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotta Eichert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Max Florian

(Address) 1108 6th St

15 Filed JUL 27 1922 19 ROBERT N. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 19 22 to July 25, 19 22

that I last saw her alive on July 25, 19 22

and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Toxs. Pregnancy

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Groskans, M. D.

19 (Address) 3104 Hartford Rd

July 25, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUL 27 1922 19

20 UNDERTAKER: Union Protestant Home - Woodall

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66319

CERTIFICATE OF DEATH.

57 D 66319

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3412 Dillon St. ST., No. WARD)

2-FULL NAME Jacob Steinlein

(a) RESIDENCE NO. 3412 Dillon St. ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Johanna Steinlein

6 DATE OF BIRTH (month, day, and year): Nov. 30 - 1849

7 AGE: Years: 72 | Months: 7 | Days: 25 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 06 V

(b) General nature of industry, business, or establishment in which employed (or employer): Copper. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Steinlein.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Magenda Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Johanna Steinlein.

(Address): 3412 Dillon St.

15 Filed JUL 27 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from May 5th. , 1922 , to July 24. , 1922 .

that I last saw him alive on July 24. , 1922 ,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Senile Neurosis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): Diabetes mellit.

(duration) one yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine Analysis

(Signed) F. J. Sebell, M. D.

, 19 (Address) 101 Dirmith St.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: July 28 1922

20 UNDERTAKER: Lilly & Julia

ADDRESS: 403 S. Mo[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66320

CERTIFICATE OF DEATH.

REGISTERED NO. 1091

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Somerset st. ST.: 10 WARD)

2-FULL NAME Charles M. Papp.

(a) RESIDENCE. NO. 1103 Somerset st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 about yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W. Cath.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah R. Papp.

6 DATE OF BIRTH (month, day, and year) March 26-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder.

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William F. Papp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. Elsie Kraft (daughter) 7724 Harford Rd.

15 JUL 27 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6 1922, to July 25 1922, that I last saw h[illegible] alive on July 25 1922, and that death occurred, on the date stated above, at 12.00 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1507 E. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 28 1922
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe

A. E.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

D 6632I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 6632I

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 828 (ST.) N Lakewood (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Bittel

(a) RESIDENCE NO. 828 ST., N Lakewood WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — John Bittel

6 DATE OF BIRTH (month, day, and year) April 10th 1852

7 AGE: Years 70 | Months 3 | Days 15 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jos. Bittel

(Address) 1417 Broom St. Mooresville

15 FILED JUL 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922 to July 25, 1922

that I last saw h[illegible] alive on July 25, 1922

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

with Acute Gastritis.

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Nephritis & Cystitis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag.

(Signed) Wm. Cappage M. D.

, 19 (Address) 2303 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Road Holy Cross Cemetery — DATE OF BURIAL: July 28 1922

20 UNDERTAKER: Lilly & Geiler — ADDRESS: 4038 Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 66322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Vincents Infant Asy.

REGISTERED NO. 113

CITY OF BALTIMORE: (No. 1401 division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Woelfer

(a) RESIDENCE NO. 1401 division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 6. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
		7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Max Woelfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Gertrude Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant St Vincent Infant Asylum (Address)

15 Robert P. Harrison, ..., 19 ... Registrar

JL 27 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27. 1922

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to July 26 1922, that I last saw him alive on July 26, 1922, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

0701

Marasmus —

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No ...

What test confirmed diagnosis? —Clinical findings.

(Signed) Chas. R. Goldborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park. DATE OF BURIAL July 28. 1922.

20 UNDERTAKER Martin Fahey & Sons. ADDRESS 1824 W. Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect. Locomotive engineer. Civil engineer. Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro enteritis.

Spec.—1-10-21—M&T—1500 Bks.

D 66323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO. 149

CITY OF BALTIMORE: (No. 176 N. Broadway ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Ruth Eyster

(a) RESIDENCE NO. Chambers Hosp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3-1860

7 AGE — Years: 62 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk. 809

(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chambersburg Pa

PARENTS

10 NAME OF FATHER: E B Eyster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: E M Smith

(Address): Chambersburg Pa

15 JUL 28 1922 ROBERT R. KNAUER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1922, to July 27, 1922, that I last saw her alive on July 27, 1922, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bilateral Pyelitis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 16 1922

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy Operation Clinical

(Signed) Richard E. Cothran, M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chambersburg Pa — DATE OF BURIAL: July 29 22

20 UNDERTAKER: H M Rowland — ADDRESS: [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66324

CERTIFICATE OF DEATH.

161 D 66324

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 32 Hafer St., ST., WARD) 20th

2-FULL NAME John Curtian

(a) RESIDENCE NO. 32 Hafer St., ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 hour ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: --

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: One hour; Months: —; Days: —; If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: -----

(b) General nature of industry, business, or establishment in which employed (or employer): -----

(c) Name of employer: -----

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Edward Curtian

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Laura Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant: Edward Curtian (Address) 32 Hafer St., City.

15 Filed JUL 28 1922 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/27/22, 19..., to 7/27/22, 19..., in July 27th, 22, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 1:45 P.m.

The CAUSE OF DEATH* was as follows:

Premature Infant (7 months)

(duration) ..... yrs. 1 hour. mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No, Date of ...

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) ..... M. D.

7/27 19... (Address) 1901 Eutaw Place, City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: July 28 1922

UNDERTAKER: F. B. Heppert — ADDRESS: 2236 Fred'k ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66325

CERTIFICATE OF DEATH.

X 100 D 66325

REGISTERED NO.

1-PLACE OF DEATH Howard A. Kelly Hosp.

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rieka M. Wade

(a) RESIDENCE. NO. Catonsville, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced ~~(husband)~~ of (or) WIFE of Wm A. Wade

6 DATE OF BIRTH (month, day, and year) Feb. 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Hiram M. Smith

11 BIRTHPLACE OF FATHER (city or town) Springfield (State or country) Vermont

12 MAIDEN NAME OF MOTHER Elizabeth Ames

13 BIRTHPLACE OF MOTHER (city or town) Springfield (State or country) Vermont.

14 Informant (Address) J P. Wade M.D. Catonsville Md.

15 Filed JUL 28 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922. to July 27, 1922.

that I last saw her alive on July 27, 1922.

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of residence

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Grant Edward, M. D.

19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edmund Va

DATE OF BURIAL: July 27 1922

20 UNDERTAKER: F O B Hepperd 2336 Fred'k

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gall stones.
Confirmed by autopsy
No cancer. No further
history.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66326

CERTIFICATE OF DEATH.

167 D 66326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4807 Hamilton Ave. (WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Zimmermann Sr

(a) RESIDENCE No. 4807 Hamilton Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline A Zimmerman

6 DATE OF BIRTH (month, day, and year): Nov 14 1843

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 04

(b) General nature of industry, business, or establishment in which employed (or employer): Hardware Business

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Geo. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas. Zimmerman Jr.

(Address) 4807 Hamilton Ave

15 Filed JUL 26 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15 1922 to July 26 1922, that I last saw him alive on July 26 1922, and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows

Cardiac Dilatation

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): old age

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ~~no~~ Physical Exam.

(Signed) Herbert C. Blake, M. D.

, 19 (Address) 1014 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. | DATE OF BURIAL: July 1922

20 UNDERTAKER: Wm. Fleckenstein Sons | ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 66327

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Wilson Heights Ave ST.; 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Carl Gollestad

(a) RESIDENCE. NO. 18 Wilson Heights Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5. 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: Geo H. Gollestad

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Martha Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belair Md

14 Informant: Geo. Gollestad
(Address): 18 Wilson Heights Ave

15 JUL 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 25, 1922, that I last saw h~~im~~ alive on July 25, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination & history of case

(Signed) Paul Brown, M. D.

July 25, 1922 (Address) 1837 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	July 29 1922
20 UNDERTAKER: David Easter	ADDRESS 916 Eutaw

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66328 — REGISTERED NO. 1129 D 66328

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3701 E Pratt (St.:) (Ward) 26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Mueller

(a) RESIDENCE. (No.) 3701 E Pratt (St.,) (Ward.)

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Mueller

6 DATE OF BIRTH (month, day, and year) Oct 18. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home - wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home. wife

(c) Name of employer Louis Mueller

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Dillgard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mr Louis Mueller 3701 E Pratt St

15 Filed JUL 29 1922 ROBERT R. KRAUSS Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to July 26, 1922, that I last saw h.. alive on July 26, 1922, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of no

Was there an autopsy? No.

What test confirmed diagnosis? same

(Signed) Jas. L. Finan, M. D.

(Address) 246 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	July 30 1922
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2040 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hurm.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66329

CERTIFICATE OF DEATH.

113 D 66329

D 66329
1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 508 Shuter St ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Raymond Hurm

(a) RESIDENCE. NO. 508 Shuter ST., 7 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs 6 mo ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: W Lite | 5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER: Jacob Hurm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER: Blanch Hubbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt

14 Informant: Jacob Hurm
(Address): 508 Shuter St

15 Filed JUL 26 1922 . 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27 1922

17 I HEREBY CERTIFY, That I attended deceased from 7-23 , 19 22 to 7-27 , 19 22 that I last saw h alive on 7-26 19 22 and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Auto-Intoxication

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Autopsy

(Signed) J. Murphy M. D.

7-27 19 22 (Address) 500 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: July 28 1922

20 UNDERTAKER: [illegible] — ADDRESS: 1906 Bolton

IMPORTANT.—THIS CERTIFICATE IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66330 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66330

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Balt. Gen. Hospital

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1213 Light ST., W (WARD)

2-FULL NAME Arthur Adams Hendricks

(a) RESIDENCE NO. 636 E. Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 5, 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6 mo		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Arthur J. Hendricks Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Agnes Kenig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Hospital Record.

(Address)

15 Filed JUL 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to July 26, 1922, that I last saw h alive on July 26, 1922, and that death occurred, on the date stated above, at abt 10 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

Dehydration. Diarrhea

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Dehydration.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 636 E. Clement St.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm B. Dalton (Asst.) M. D.

, 19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill. DATE OF BURIAL 7-28 1922

20 UNDERTAKER E & B Harle ADDRESS 16 E Mt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66331 ~~H~~EALTH DEPARTMENT—CITY OF BALTIMORE D 66331

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1702-Park-Ave. ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME GEORGE LAWRENCE IRVIN

(a) RESIDENCE. No. 1702-Park-Av. ST., 14 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? 73 yrs. 10 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Walkley Irvin

6 DATE OF BIRTH (month, day, and year) Sep't-24-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres't Carlin-FultonCo.

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware

(c) Name of employer (Self; as above stated)

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER George W. Irvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Eliza deLacour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington Delaware

14 Informant (Address) Mary E. Irvin, (wife) 1702-Park-Av., City.

15 Filed JUL 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 22nd, 1922, to July 26, 1922, that I last saw him alive on July 26, 1922, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchs-pneumonia associated with relighting up tuberculosis, dormant since Childhood.

(duration) ✓ yrs. ✓ mos. 35 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis, preceding. (duration) ✓ yrs. ✓ mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Microscope for T.B.

(Signed) Eli Van Hyo M. D.

7.27, 1922 (Address) 815 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — DATE OF BURIAL: July-28-22

20 UNDERTAKER: STEWART & MOWEN COMPANY (Charles F. Mowen, President) — ADDRESS: 1400 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSIC CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

157141 D 66332

HEALTH DEPARTMENT—CITY OF BALTIMORE 001

CERTIFICATE OF DEATH.

6 161 D 66332

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: (6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry Toard.

(a) RESIDENCE. NO. 1112 N. Chapel St. CITY.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. Unknown mos. ... How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

WARD

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~: Nellie Toard (Mother)

6 DATE OF BIRTH (month, day, and year): June 29-22

7 AGE: Years — Months 1 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Peter Toard

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Nellie Krayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Johns Hopkins Hospital

(Address): Toards

Filed JUL 28 1922, 19...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1922, to July 27, 1922, that I last saw h.i.m alive on July 27, 1922, and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edwin Mason, M. D.

7/27 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery.

DATE OF BURIAL: July 28 1922

20 UNDERTAKER: Milton Davis

ADDRESS: 316 N Eden St

I. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Jamuk)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66333

CERTIFICATE OF DEATH.

100-001 D 66333

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 S Durham ST., V WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hellen Jamuk

(a) RESIDENCE NO. 413 S Durham ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., If of foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 26 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Jamuk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Husband Father
(Address)

15 JUL 28 1922 GLG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-1922

17

I HEREBY CERTIFY, That I attended deceased from July 22nd, 1922, to July 27, 1922, that I last saw her alive on July 26th, 1922 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laryngeal Exam

(Signed) J Wolfe, M. D.

, 19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	July 28 1922

20 UNDERTAKER John A Weber ADDRESS 1803 Bank

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66334

CERTIFICATE OF DEATH.

74 B 66334

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 207 Aisquith (St.) (5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margrett Wilmore

(a) RESIDENCE. (No.) 207 Aisquith St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widow

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 67 — Months: ✓ — Days: ✓ — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ✓

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ✓

14 Informant: Theodore White

(Address) 113 S. Wolfe St.

15 Filed JUL 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to July 26, 1922, that I last saw h[er] alive on July 26, 1922, and that death occurred, on the date stated above, at 1.25 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. 1 mos. 23 ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) Edward Fisher, M. D.

7-27 1922 (Address) 1612 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 29 1922
20 UNDERTAKER	ADDRESS
Theodore G. White	113 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

D 66335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66335

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1629 Madison MAve ST., 14 WARD)

2-FULL NAME Louis Cohen

(a) RESIDENCE NO. 1629 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Cohen

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 45 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Shemil Choen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unkown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Balto

15 Filed JUL 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/25/22, 19 , to 7/27/22, 19 , that I last saw h(im) alive on 7/27/22, 19 , and that death occurred, on the date stated above, at 10 am m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lungs

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Section of gland

(Signed) Zigmond, M. D.

7/27, 1922 (Address) 1402 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: July 28 1922

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

I. B. WHITE PRINT, MIMEOGRAPHING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66336

CERTIFICATE OF DEATH.

44 D 66336

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 S. East ave ST., | WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Benner

(a) RESIDENCE NO. 1102 S. East ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lydia J. Benner.

6 DATE OF BIRTH (month, day, and year) Oct. 16 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	49	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick-Layer D11

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer S. Ofroll 627 N. Kenwood ave

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry J. Benner.

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Lydia J. Benner. (Address) 1102 S. East ave

15 Filed JUL 28 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1922, to July 26th, 1922, that I last saw him alive on July 25th, 1922, and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Estimated (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? At Johns Hopkins Hospital

(Signed) D.W. Jones, M. D.

7/27/1922 (Address) 1011 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL July 29 1922

20 UNDERTAKER Zinkler + Zinkler

ADDRESS 1739 E. Eager

N. B.—THE ATTENTION OF PHYSICIANS IS CALLED TO THE FACT THAT THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66337

CERTIFICATE OF DEATH

D 66337

1 PLACE OF DEATH — REGISTERED NO. C 37

CITY OF BALTIMORE (No. 734 S. Linwood Ave ST: / WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Maria Finger

(Residence in Baltimore: No. 734 S Linwood Ave ST: 24 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Nov. (Month) 13 (Day), 1897 (Year)

7 AGE: 24 yrs. 8 mos. 13 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Sales Lady 064
(b) General nature of industry, business, or establishment in which employed (or employer): Virginia Dare Chocolate Co

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Conrad Finger

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie E. Heubsch

13 BIRTHPLACE OF MOTHER (State or country): Memphis, Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie E. Finger

(Address) 734 S. Linwood Ave

15

Filed JUL 28 1922 191 — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 26 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1922, to July 26 1922

that I saw her alive on July 26, 1922

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Burkel M. D.

July 27, 1922 (Address) 3042 Frederick Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: July 29, 1922

20 UNDERTAKER: Zirkler + Zirkler — ADDRESS: 1739 E. Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66338

CERTIFICATE OF DEATH.

100-001 D 66338

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: W Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Kipps

(a) RESIDENCE. No. 3510 O'Donnell St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address): Municipal Hospital.

15 JUL 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1921 to July 27, 1922 that I last saw her alive on July 27, 1922, and that death occurred, on the date stated above, at 12:29 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 3 days

CONTRIBUTORY (Secondary) (duration) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde Mitchell, M. D.

7/27/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: July 29 1922

20 UNDERTAKER: Zirkler & Zirkler

ADDRESS 1739 Eager

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66339

CERTIFICATE OF DEATH.

35D 66339

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST.: (WARD 14)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Mahlon G Sauer

(a) RESIDENCE. No. 116 East Ave. St. WARD. Hagerstown, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, (widowed) or divorced
HUSBAND of
(or) WIFE of Mrs Mahlon G. Sauer

6 DATE OF BIRTH (month, day, and year) August 2nd 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 059

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Eli Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Delilah Sager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant E. R. Sauer
(Address) Hagerstown Md

15 Filed JUL 28 1922 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 19 22, to July 17th 19 22,
that I last saw h. alive on July 17th 19 22,
and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative shock 6 hrs. after
Fibrosa (duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 17th, 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Jno. R. Quinn M. D.

July 17th, 1922 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown, Md DATE OF BURIAL July 30 1922

20 UNDERTAKER Wm J Tucker & Son ADDRESS Hagerstown Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66340

CERTIFICATE OF DEATH.

D 66340

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1915 Hanover ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number

2-FULL NAME William A Shickels

(a) RESIDENCE No. 1915 Hanover ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Gladys Shickels

6 DATE OF BIRTH (month, day, and year) 8-19-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer) United Ry & Elec Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Shickels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Lusby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Gladys Shickels

(Address) 1915 Hanover St

15 Filed JUL 28 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May — 1920 to July 27, 1922, that I last saw him alive on July 27 — 1922, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G. E. Buxton, M. D.

7/27, 1922 (Address) 301 E 6th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: July 31 1922

20 UNDERTAKER: John F Denny — ADDRESS: 715 Lombard St

N. B.—WRITE PLAINLY, WITH PEN AND INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6634 [redacted] D 6634 [redacted]

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 Broadway Court St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Webster

(Residence in Baltimore: No. 23 Broadway Court St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Yard

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jones

(Address) 23 Broadway Court

15- JUL 27 1922

Filed....., 191.... J E Webster Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1922, to July 26 1922, that I saw him alive on July 25 1922, and that death occurred, on the date stated above, at 3.30a m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E P Potter M. D.

July 27, 1922. (Address) 1711 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, yrs. mos. In State, yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

OK, Thos. B. Norton M.D.

CORONER FOR BALTIMORE CITY—EASTERN DISTRICT

19-PLACE OF BURIAL OR REMOVAL. Laurel

DATE OF BURIAL. July 29, 1922

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

E. of Broadway running north of Lombard St.
at Half Block.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide: Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides; Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66342

CERTIFICATE OF DEATH.

D 66342

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 3100 Ellerslie St (Ward) 9

2-FULL NAME Montague A Jolliffe

(a) RESIDENCE NO. 3100 Ellerslie ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 21 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Churchill P Jolliffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary E Jolliffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Jolliffe
(Address) 3100 Ellerslie St

15 Filed JUL 26 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1922, to July 27th, 1922, that I last saw h in alive on July 27th, 1922, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Spinal
Cerebro Meningitis.

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Exhaustion.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Spinal puncture

(Signed) Geo. H. E. Cates M. D.

, 19 (Address) 2409 Med. av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	July 28 1922
20 UNDERTAKER	ADDRESS
Eckenrodt & Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 66343 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 135 D 66343

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital. St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Johnson

(a) RESIDENCE. No. Drury, Md. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth Johnson.

6 DATE OF BIRTH (month, day, and year) 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. O/S

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Alfred Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER D. Bevery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant James A. Johnson

(Address) Drury Md.

Filed JUL 28 1922 19 LLS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1922.

17 I HEREBY CERTIFY, That I attended deceased from 6/26, 1922, to 7/27, 1922, that I last saw him alive on 7/27, 1922; and that death occurred, on the date stated above, at 2.00 P m.

The CAUSE OF DEATH* was as follows:

Respiratory failure following use of novo-cain in spinal anaesthesia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cystitis, hypertrophied prostate, vesico vaginal fistula (duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/17/22.

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) J. Willis Compton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druery's Cemetery	July 28 1922
20 UNDERTAKER B & H Hopping	ADDRESS Annapolis

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66344

CERTIFICATE OF DEATH

57 D 66344

REGISTERED NO.

1-PLACE OF DEATH Balt. Eye Ear + Throat Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. Baltimore Md. ST.: 3 WARD)

2-FULL NAME Mrs. Sallie Hutton

(a) RESIDENCE. NO. 28 S. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Robert Hutton.

6 DATE OF BIRTH (month, day, and year) Oct 14th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Caroline Co

PARENTS

10 NAME OF FATHER James Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Elizabeth Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Mr. K. Hutton
(Address) 28 S. Broadway.

15 JUL 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to July 27, 1922, that I last saw her alive on July 26, 1922, and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis, toxemia,
Diabetes (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Hospl.

Did an operation precede death? Yes Date of July 1922

Was there an autopsy? No-

What test confirmed diagnosis? Physical signs.

(Signed) H K Finch, M. D.

, 19 (Address) 513 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	July 29th 1922
20 UNDERTAKER	ADDRESS
Mrs Johannah Pancoe	1004 Aisquith

Spec.—1-10-21—M&T—1500 Bks.

D 66345

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-D 66345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 Frederick St., 70 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Lewis Eyerly Jr

(a) RESIDENCE NO. 2317 Frederick St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 26-22

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Harry L Eyerly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Rebecca M Bugay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Harry L Eyerly 2317 Frederick Ave

15 Filed 7/29 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to July 27, 1922, that I last saw h.. alive on July 26, 1922, and that death occurred, on the date stated above, at 10 15 m.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

7/28 1922 *Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 28 1922

20 UNDERTAKER: H. S. Stephens — ADDRESS: 2256 Fleet Ave

D 66346 HEALTH DEPARTMENT—CITY OF BALTIMORE 17 D 66346

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1816 Ashburton St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bluma Forschleger

(Residence in Baltimore: No. 1816 Ashburton St.; 19 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): M

6-DATE OF BIRTH: January 17 1903 (Month) (Day) (Year)

7-AGE: 59 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Russia

PARENTS

10-NAME OF FATHER: Michel Stern

11-BIRTHPLACE OF FATHER. (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Jenette Strauer

13-BIRTHPLACE OF MOTHER. (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Lewis

(Address): 1439 E Balt St

15- JUL 28 1922 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 27 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, an (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Indigestion
Emphysema

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) yrs. mos. ds.

(Signed) G. E. Blade M. D.
(Coroner)

July 27 192.. (Address) 143 N. Broad

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale DATE OF BURIAL. July 28 19..

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66347 80,

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66347

CERTIFICATE OF DEATH.

x132

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No Johns Hopkins Hospital ST.: ? WARD)

2-FULL NAME Col. James Fraser Macdonald.

(a) RESIDENCE. No Westminster Hotel Toronto Canada WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Six weeks Yrs. How long in U. S., If of foreign birth? Yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Miss M. Macdonald (sister)

6 DATE OF BIRTH (month, day, and year) Aug 28-1867

7 AGE: Years 54 Months 11 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Military

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Donald Macdonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Wilhelmine Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed Jul 28, 1922 Robert P. Harrison, Registrar

JUL 28 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to July 28, 1922, that I last saw h[illegible] alive on July 28, 1922, and that death occurred, on the date stated above, at 2.20 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Pyelitis - ureteral

(duration) 1 mo. 2 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary) Renal calculi

(duration) 18 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Toronto, Canada.

Did an operation precede death? Yes Date of 7/21/22

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm Campbell Cobb, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Niagara on the Lake Canada — DATE OF BURIAL: July 28 1922

20 UNDERTAKER: John O'Mitchell — ADDRESS: 1201 N. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66348

HEALTH DEPARTMENT—CITY OF BALTIMORE

165 D 66348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Mercy Hospital St., 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Henry Heuze

(Residence in Baltimore: No. 1818 Barclay St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Nov. 7, 1879 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
42 yrs. 8 mos. 20 ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Golf Instructor
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE. (State or Country). Balto. Co., Md.

PARENTS

10-NAME OF FATHER. Wm. H. Henze

11-BIRTHPLACE OF FATHER. (State or Country) Balto. Co. Md.

12-MAIDEN NAME OF MOTHER. Julia Burns

13-BIRTHPLACE OF MOTHER. (State or Country). Harford Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Henze

(Address) 1818 Barcley St.

15- Filed 7 28 1922 19.. Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 27 192.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Poisoning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) C. E. Blades M. D.

July 27 192.. (Address) 173 E. Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	7/29/22 19..

20-UNDERTAKER. Henry W. Mears & Son. ADDRESS 805 N. Calvert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66349

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1913 E. North Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene E. Graham

(Residence in Baltimore: No. 1913 E. North Ave St.; yrs. 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March 24, 1857
(Month) (Day) (Year)

7-AGE. 65 yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Inspector 086
(b) General nature of Industry, business, or establishment in which employed (or employer): Amer. Agril. Chem. Co.

9-BIRTHPLACE, (State or Country). Caroline Co., Md.

PARENTS.

10-NAME OF FATHER. Robert E. Graham.

11-BIRTHPLACE OF FATHER, (State or Country). Deleware

12-MAIDEN NAME OF MOTHER. Sarah E. Melvin

13-BIRTHPLACE OF MOTHER, (State or Country). Caroline Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Graham

(Address) 1913 East North Ave.

15- Filed 7 28 1922, 192

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26, 192
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

(Signed) Geo. Claude Ritchie M. D.
(Coroner.)

July 27 192 (Address) 120 E. Army

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cemetery	7/29/22 19

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son,	805 W. Calvert

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66350

CERTIFICATE OF DEATH.

D 66350

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1521 Bolton ST.: 14 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Warner Jenkins

(a) RESIDENCE. No. 1521 Bolton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Effie Johnston Jenkins

6 DATE OF BIRTH (month, day, and year) Aug. 4 1837

7 AGE — Years: 82 — Months: 11 — Days: 23 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Office

(b) General nature of industry, business, or establishment in which employed (or employer): Mineral

(c) Name of employer: Director

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry W Jenkins

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Ann Warner

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Md.

14 Informant (Address): Mrs. Effie Johnston Jenkins 1521 Bolton St.

15 Filed ... 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

JUL 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24th, 1922, to July 27th 1922, that I last saw him alive on July 27th, 1922, and that death occurred, on the date stated above, at 1240 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis (2nd hemiplegic attack)

(duration) ✓ yrs. ✓ mos. 9 ds.

CONTRIBUTORY (Secondary) Senile arteriosclerosis

(duration) Many yrs. • mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of •

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) E. W. Van Ness, M. D.

19 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 7-29 192

20 UNDERTAKER: Henry W Jenkins & Sons Co.

ADDRESS: McCulloh Overhead.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Benhoff)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66351

D 66351

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 200 N Kenwood ave ST., (WARD)

2-FULL NAME George F. Benhoff Sr

(a) RESIDENCE NO. 200 N Kenwood ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jan 14 1850

6 DATE OF BIRTH (month, day, and year): Jan 14 1850

7 AGE — Years: 72 Months: 6 Days: 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Navy Yard

(c) Name of employer: Washington D C

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Fred. Benhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs F C Bowen

(Address): 200 N Kenwood

15 Filed ....., 19..... Registrar

28 1922

Robert P. Harriden, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 14, 19 22 to July 27, 19 22

that I last saw h/h alive on July 27, 19 22

and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

from history (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J H Cushamp M. D.

July 28, 19 22 (Address) 3100 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemet

DATE OF BURIAL: July 29 1922

20 UNDERTAKER: Gilbert H Shriver

ADDRESS: 1018 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66352

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2836 Rayner Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Oliver Holbrook

(a) RESIDENCE NO. 2836 Rayner Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Holbrook

6 DATE OF BIRTH (month, day, and year): Mar 11 1845

7 AGE: Years 77 Months 4 Days 16 If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 45

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Seth Holbrook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Louisa Clement

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Clayton 2836 Rayner

15 Filed JUL 29 1922, 19 Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to July 27, 1922, that I last saw him alive on July 27, 1922 and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Am yrs. mos ds.

CONTRIBUTORY (Secondary): Senile Gangrene

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical ex

(Signed) L. M. Lamperin, M. D.

July 29 1922 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 31 1922

20 UNDERTAKER: H. A. Richardson & Co — ADDRESS: Balto Md

I.—WHITE PLANET, WHITE CAPABILITIES. This is a Permanent Record. Please write plainly. Every question must be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 29 1922

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66353

CERTIFICATE OF DEATH.

D 66353

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1545 S. Charles ST. 23rd (WARD) REGISTERED No. C

2-FULL NAME Grace V. Adams

(Residence in Baltimore: No.) 1545 S. Charles

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

1 hour 45 minutes

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	M.

6-DATE OF BIRTH, July (Month) 28 (Day), 1922 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 1 hrs. or 45 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Irving J. Adams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Grace V. Fields

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irving J. Adams

(Address) 1545 S Charles St

15- July 29 1922

Robert P. Harrison,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28th (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28th 1922, to July 28th 1922, that I saw h[illegible] alive on July 28th 1922, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Probably superinduced by Liver)

(Duration) 1 hour 45 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Leibel M.D.

7/28, 1922 (Address) 124 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Cem	July 31, 1922
20-UNDERTAKER	ADDRESS
Eschleman Son	131 Hanover St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 66354

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66354

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Wyeth ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Gener

(Residence in Baltimore: No. 606 Wyeth St.; 74 yrs. 7 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Dec. 12th, 1847 (Month) (Day) (Year)

7-AGE, 74 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Rathmiller

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Wilhelmina Weber

13-BIRTHPLACE OF MOTHER (State or Country), Germy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Gener

(Address) 606 Wyeth St

15-

Filed.....1922..... Robert F. Harrison, Registrar.

29 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7th 1922 to July 28th 1922 that I saw her alive on July 27th 1922, and that death occurred, on the date stated above, at 6.15 A.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration)....yrs....mos....ds.

(Signed) J. Boulton M. D.

7-28-1922 (Address) 654 Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Western Cem	July 31, 1922
20-UNDERTAKER	ADDRESS
B. Schmaedeke	Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66355

CERTIFICATE OF DEATH.

101-001

D 66355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 171 W. Hamburg ST., 23 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie K. Golder

(a) RESIDENCE No. 171 W. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland

PARENTS

10 NAME OF FATHER Edward Trent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Millie Torrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Jones

(Address) 171 W. Hamburg St.

15 July 29 1922 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Jun 26, 1922, to July 26, 1922, that I last saw h alive on July 26, 1922, and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) C. F. Hooker M. D.

July 29, 1922 (Address) 912 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL July 30 1922.

20 UNDERTAKER John H. Toadvine ADDRESS 1412 N Hill St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

V. 59'52

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66356

CERTIFICATE OF DEATH.

101-001 D 66356

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 814 Dolphin ST., 11 WARD)

2-FULL NAME Roseman Louise Washington

(a) RESIDENCE NO. 814 Dolphin ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 18th 21,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	X	9.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER William ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Sallie Washington

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Louise Washington
(Address) 814 N. Dol. Ave.

15 Filed JUL 29 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 22

17 I HEREBY CERTIFY, That I attended deceased from July 26th 19 22 to July 27th 19 22

that I last saw he alive on July 27th 19 22

and that death occurred, on the date stated above, at 8-45 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ✓ ds.

CONTRIBUTORY (Secondary) Malnutrition ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. M. Ellis M. D.

19 (Address) 924 Mosher Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL July 29 19 22

20 UNDERTAKER Lund Eaglin

ADDRESS 916 Penn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

157295. D 66357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

123 D 66357

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. (St.:) (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Mc Dermott.

(a) RESIDENCE. No. 804 N. Burley St., City ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mrs Mary Mc Dermott

6 DATE OF BIRTH (month, day, and year): March 26-1866

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Charles Mc Dermott.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Harriet Hessick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed ..., 1922, ... Registrar

Robert P. Garrison

Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922, to July 27, 1922, that I last saw him alive on July 27, 1922, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis post operative operation for Gall Stones.

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Gall Stones

(duration) 5 yrs. ? mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7-24-22

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Course

(Signed) Julian D Hart. M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	July 31 — 1922
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmount Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66358

CERTIFICATE OF DEATH.

3 / D 66358

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Municipal tuberculosis Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brown

(a) RESIDENCE. NO. 1628 N. Washington st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Samuel Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Tydings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M. T. H.

JUL 29 1922 , 19 Robert F. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1921, to July 28, 1922, that I last saw her alive on July 28, 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dadaglucci M. D.

7-28-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	July 29 1922
20 UNDERTAKER	ADDRESS 1442
Robt. T. Turner Inc.	N. Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66359

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3909 Forest Park Ave ST., 15 WARD)

2-FULL NAME Malcolm Clarke

(a) RESIDENCE NO. 3909 Forest Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22nd 1922

7 AGE — Years: — Months: 1 — Days: 6 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James S Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Myrtle Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James Clarke

(Address) 3909 Forest Park Ave

15 JUL 29 1922, 19

Robert F. Garrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to July 28, 1922, that I last saw her alive on July 28, 1922, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon N. Condon, M. D.

, 19 (Address) 750 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 29 1922

20 UNDERTAKER: Bott & Turner — ADDRESS 1414 W Baltimore St

I.—WRITE PLAINLY, with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma. Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior

Smith & Bolton—11

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66360 — 14 001 — D 66360

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 N Chester St.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Ehlen

(Residence in Baltimore: No. 1908 N Chester St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 28, 1856 (Month) (Day) (Year)

7-AGE, 66 yrs. 7 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob C Snyder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eliza Hamilton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred. Ehlen

(Address) 1908 N Chester

15-

Filed ....., 191..

Registrar.

JUL 29 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8 1922, to July 27 1922.
that I saw h[illegible] alive on July 27 1922
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Wm. J. Kerr, M. D.

July 27 191.. (Address) 201 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, July 29, 22

20-UNDERTAKER Robt. Johnson — ADDRESS N. Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66361

HEALTH DEPARTMENT—CITY OF BALTIMORE

172D-002 66361

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1809 N. Caroline ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Le. Smith

(a) RESIDENCE NO. 1809 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Johnson Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Emma L. Taylor (Address) 1809 N. Caroline.

15 Filed JUL 29 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1922

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to July 28, 1922, that I last saw her alive on July 27, 1922, and that death occurred, on the date stated above, at 4-20 a. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age + Cerebral Hem

(duration) about yrs. mos ds.

CONTRIBUTORY (Secondary) Infirmities + Cerebral Hem

(duration) about yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Infirmities

(Signed) R. O. Carman, M. D.

7-28-1922 (Address) 1701 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 31 1922

20 UNDERTAKER Wm Cook — ADDRESS 47 & N

Burial Permit Given

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66362

D 66362

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST.: 76 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Morrow

(a) RESIDENCE. NO. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Susan Morrow

6 DATE OF BIRTH (month, day, and year) 1852 12/25

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseshoer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

036

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Thos Morrow

11 BIRTHPLACE OF FATHER (city or town) ~~Unknown~~ (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Hamilton

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Ireland

14 Informant Hospital Records,

(Address) Municipal Hospital

15 Filed JUL 29 1922 Robert P. Harrison, Registrar

~~Burial Permit Clerk,~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from August 23. 1918. to July 28. 1922. that I last saw h im alive on July 27 1922. and that death occurred, on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/28/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 31 22

20 UNDERTAKER William Cook — ADDRESS 502 E Hoff.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66363

CERTIFICATE OF DEATH.

117 D 66363

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Jno Gen Hospt ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno L. Wilson

(a) RESIDENCE. No. 20 W Woodlawn Ave ST., Woodlawn Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Fredia V Wilson

6 DATE OF BIRTH (month, day, and year) Feb 1-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Jno L Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Ellen Alford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Self. (Address)

15 Filed JUL 29 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/1922

17 I HEREBY CERTIFY, That I attended deceased from 7/23/1922, 19 to 7/28/1922, 19, that I last saw h alive on 7/28/1922, 19, and that death occurred, on the date stated above, at 6 45 m.

The CAUSE OF DEATH* was as follows:

General paresis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (hypostatic)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 6/13/22

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Compton, M. D.

, 19 (Address) Autopsy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	7/31 1922
20 UNDERTAKER Wm Coale	ADDRESS 502 E Lex Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66364

CERTIFICATE OF DEATH.

113 D 66364

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 709 W REDWOOD ST.: 4 WARD)

2-FULL NAME BRANISLOVAS GRIBAS

(a) RESIDENCE. No. 709 W REDWOOD ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Gribas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER M. Yvalackute

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithvania

14 Informant Joseph Gribas
(Address) 709 W Redwood Street

15 Filed July 29 1922

19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day, and year) July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922, to July 25, 1922, that I last saw h[illegible] alive on July 25, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Glassman M. D.

July 29 1922 (Address) 2681 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 29 1922
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca st

J. G.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

29 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66365

CERTIFICATE OF DEATH.

161-901

D 66365

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 804 E Fort Ave ST.: 22 WARD)

2-FULL NAME Infant of Martin and May Reines

(a) RESIDENCE. NO. 804 E Fort Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, ~~Married~~, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7.28.22

7 AGE Years Months Days — If LESS than 1 day, hrs. or min

Lived 9½ hours
7½ Foetal Months

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Martin Reines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Berner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Martin Reines 804 E Fort Ave

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

L 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7.28 1922

17 I HEREBY CERTIFY, That I attended deceased from 7.28, 1922, to 7.28, 1922, that I last saw him alive on 7.28, 1922, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Unknown)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. Darlington, M. D.

7.28 1922 Address 102 E Hoffman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. — DATE OF BURIAL July 28 22

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 N. Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

15 7311.

D 66366

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31

D 66366

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL. WARD 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Seagle.

(a) RESIDENCE. No. Forest Hill, Harford County, Maryland. WARD. 7 (Forest Hill Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Mrs. John Seagle (Married)

6 DATE OF BIRTH (month, day, and year) June 22, 1921.

7 AGE: Years 1 Months 1 Days 7 If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: John Seagle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Grace Grafton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Forest Hill, Maryland.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Forest Hill

15 Filed JUL 29 1922 Robert P. Harrison, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922 to July 29, 1922, that I last saw h[illegible] alive on July 29, 1922, and that death occurred, on the date stated above, at 1 45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clem S. Mason, M. D.

7/29, 1922 (Address) Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Hill Harford Co Md

DATE OF BURIAL: July 29 1922

20 UNDERTAKER: STEWART & HOWE

ADDRESS: 1828 W. NORTH AVE

JUL 29 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66367

CERTIFICATE OF DEATH

D 66367

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 711 Light ST. 42 WARD 100

2-FULL NAME Donald C. Carter

(a) RESIDENCE NO. 711 Light st ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 24 1922

7 AGE: Years — Months 6 — Days 5 — If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Carroll M Carter
11 BIRTHPLACE OF FATHER (city or town) (State or country): Lancaster Co Va
12 MAIDEN NAME OF MOTHER: Loraine F Wilkes
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md

14 Informant: Carroll M Carter
(Address): 701 Light st

15 Filed 19 — Registrar

Robert F. Harrison,
Burial Permit Clerk.

JUL 29 1922

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28th, 1922, to July 28, 1922.
That I last saw him alive on July 28th, 1922
and that death occurred, on the date stated above, at 2 45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia (Acute Congestive Form)
(duration) 4 hours 15 minutes — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical findings

(Signed) Harry Kleibel M.D.
1922 (Address) 1324 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Catonsville
DATE OF BURIAL: July 29 1922

20 UNDERTAKER: John F Denny
ADDRESS: 715 Light st

Spec.—8-24-14—M. & T.—2000 Bks.

D 66368

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 66368

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Chester ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Hannan

(Residence in Baltimore: No. 208 S. Chester St ST.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)

6-DATE OF BIRTH, July 20, 1853 (Month) (Day) (Year)

7-AGE, 69 yrs. ....mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Letter Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Caspar Hannan

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorthea

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hannan

(Address) 208 S Chester

15-

Filed JUL 29 1922, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1922, to July 28 1922, that I saw h~~is~~er alive on July 27 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) ....yrs. 1½ mos. ....ds.

(Signed) Geo. Keller M. D.

7/29/22, 191.. (Address) 1937 Gough St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, July 31, 1922

20-UNDERTAKER J. Ullrich

ADDRESS 2008 Aisquith

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66369

CERTIFICATE OF DEATH.

113 D 66369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Clarkson St. 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doney Sweet

(Residence in Baltimore: No. 1735 Clarkson St.: ..... yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE among the items to be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 6 (Day), 1922 (Year)

7-AGE. ..... yrs. 6 mos. 23 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George F Sweet

11-BIRTHPLACE OF FATHER (State or Country), Della Md

12-MAIDEN NAME OF MOTHER Edna Glaser

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George F Sweet

(Address) 1735 Clarkson St

15-

Filed JUL 29 1922 Robert P. Harrison, Registrar.

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28 1922, to July 28 1922, that I saw h[illegible] alive on July 28 1922, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John A Shadowen M. D.

7-29, 1922 (Address) 638 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1735 Clarkson

19-PLACE OF BURIAL OR REMOVAL. Della Cemetery (Ellicott City) DATE OF BURIAL, July 31, 1922

20-UNDERTAKER James Dignan & Son ADDRESS 1000 S. Paca St.

D 66370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66370

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 578 Oxford St. 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Sallie

(Residence in Baltimore: No. 578 Oxford St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Sept. (Month) 15 (Day) 1920 (Year)

7-AGE: 1 yrs. 10 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: James Sallie

11-BIRTHPLACE OF FATHER. (State or Country): Va

12-MAIDEN NAME OF MOTHER: Mary Smith

13-BIRTHPLACE OF MOTHER. (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Sallie

(Address) 578 N. Eddell St

15-

Filed ... 192...

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28- (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brain - Pneumonia

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jos Luther Blood M. D.

(Coroner)

July 28 192 (Address) 43 W. Lenox

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt Auburn Cem July 29 192 2

20-UNDERTAKER. ADDRESS

Samuel Beasley, N Eddell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

was under attention Dr. Bosch's J. H. Hospital

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 20 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis.*
Cellulitis.	*Gangrene.*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas.*	*Peritonitis.*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66371

D 66371

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 126 S. Dallas ST.: 3 WARD)

2-FULL NAME Mary Rich

(a) RESIDENCE. No. 126 S Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer Work at home

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Mackt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ella Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Lena Rich 126 S Dallas St

15 Filed JUL 28 1922 19 Robt P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1922, to July 27 1922, that I last saw h.er alive on July 27 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

a Chronic Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

7-28 1922 Address 1822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL July 30 19

UNDERTAKER R E Gross ADDRESS 1400 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66372

CERTIFICATE OF DEATH.

D 66372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229 Division ST.; 14 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte L. Nelson

(Residence in Baltimore: No. 2229 Division St.; 20 yrs. mos ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	Colored	Single

6-DATE OF BIRTH, Dec 15, 1896 (Month) (Day) (Year)

7-AGE, 25 yrs. 7 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John A Nelson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Brian McCarl

(Address) 2229 Division

15-

Filed ....., 191.....

Registrar.

Robert T. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH, July 27, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1921, to July 27 1922, that I saw h[illegible] alive on July 27 1922, and that death occurred, on the date stated above, at 8.55 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Fred C Jewett M. D.

July 27, 1922 (Address) 2516 Penn Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Rev. Aulrus Cemetery	July 30, 1922
20-UNDERTAKER, James F. Kane	ADDRESS 1303 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66373

CERTIFICATE OF DEATH.

113 D 66373

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 729 East Fort Ave ST., W WARD)

2-FULL NAME John Joseph O'Callaghan

(a) RESIDENCE NO. 729 E. Fort ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 23-1922

7 AGE — Years: — Months: 6 Days: 5 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Joseph O'Callaghan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Margaret Corrigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John J. O'Callaghan

(Address) 729 E. Fort Av

29 1922 Filed ..... 19 Robert P. Harrison, Registrar

By Marshal Pratt Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1922, to July 28 1922.

that I last saw him alive on July 28 1922,

and that death occurred, on the date stated above, at 545 P m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 7-8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? nr Date of .....

Was there an autopsy? nr

What test confirmed diagnosis?

(Signed) E. F. Haar, M. D.

7. 29. 1922 (Address) 801 E. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A.A.C Md

DATE OF BURIAL: July 29 1922

20 UNDERTAKER: William Cook

ADDRESS: 501 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66374

CERTIFICATE OF DEATH.

6 113 D 66374

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Dallas St. ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Patterson

(Residence in Baltimore: No. 417 N Dallas St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... Jan 13 (Month) ..... 1 (Day), ... 1922 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 6 mos. 15 ds.	..... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Samuel Patterson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Violet Perkins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Violet Patterson

(Address) ..... 417 N. Dallas St.

15-Filed JUL 30 1922, 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) ..... 28 (Day), ... 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1922, to July 28 1922, that I saw h.. alive on July 27 1922, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

..... (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) ..... Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Edward E. Gallagher M. D.

July 28, 1922 (Address) 1317 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, 7/30/1922

20-UNDERTAKER James R. Kimmel — ADDRESS 1532 Madison St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66375

CERTIFICATE OF DEATH.

14-001

D 66375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Heuskells Road-Md ST., 25 WARD)

2-FULL NAME Georgiana Freeman

(a) RESIDENCE NO. Heuskells Road Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Freeman

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years: 50 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Md

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Marys Co

PARENTS

10 NAME OF FATHER: Wilford Colleen

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co

14 Informant: Mary Fields

(Address) Heuskells Road Md

15 JUL 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to July 28, 1922

that I last saw h[illegible] alive on July 28, 1922,

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Appendicitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

July 29, 1922 (Address) Public Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marley Neck Cemetery — DATE OF BURIAL: 7/31/1922

20 UNDERTAKER: James In. Skinner — ADDRESS: 620 E. Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66376

HEALTH DEPARTMENT—CITY OF BALTIMORE

100,001

D 66376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 100 N. Bond St. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjeman Feinberg

(a) RESIDENCE NO. 100 N. Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Sarah Feinberg

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 65 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery 037

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Baltimore St

15 JUL 30 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July - 21, 1922, to July 28 - 1922, that I last saw h— alive on July 28, 1922, and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH* was as follows:

Chronic Emphysema (Bronchial Asthma)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho-Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? —

What test confirmed diagnosis? usual

(Signed) Jos. L. Bromer, M. D.

7/29, 1922 (Address) 125 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrer Rosedale — DATE OF BURIAL 7/30 1922

20 UNDERTAKER: Jack Lewis 1439 E Baltimore St — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—11. P. Co.—1000 Rks.

D 66377

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100,001

D 66377

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Hettleman.

(a) RESIDENCE. NO. 311 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Hettleman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Retired Dealer~~

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer 045

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Malach Hettleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Fannie Hettleman
(Address) 311 N Broadway

15 Filed JUL 30 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July 23 . 1922 . to July 29 . 1922

That I last saw h[illegible] alive on July 29 . 1922

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate (duration) yrs. 10 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Moses Hettleman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	July 30 1922

20 UNDERTAKER Jack Levis ADDRESS 1434 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbks.

Fleitman

D 66378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 66378

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 12 WARD)

2-FULL NAME Sonny Fleitman

(a) RESIDENCE NO. 1825 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Fleitman

6 DATE OF BIRTH (month, day, and year): April 30, 1862

7 AGE: Years 60 Months 2 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Samuel Fleitman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Gerda Graupe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Mercy Hosp Records

15 Filed JUL 30 1922 ROBERT R. KRAULER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1922, to July 28, 1922

that I last saw h[illegible] alive on July 28, 1922

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary

7 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 21 '22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. H. Finney M.D.

1922 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rit Carmel — DATE OF BURIAL: July 30 1922

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66379

CERTIFICATE OF DEATH.

38

D 66379

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

2-FULL NAME John Reddick (Raddick)

(a) RESIDENCE NO. 658 Bradley st. ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Not given

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Willis Reddick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Virginia Brothers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) M. T. Hospital

15 Filed JUL 30 1922 19 ROBERT R. KRAUTH, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to July 28, 1922, that I last saw him alive on July 28, 1922, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic broncho-pneumonia.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-Ray, Blood Exam.

(Signed) Francis L. Pedrychacel, M. D.

7-29-, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Pisgah Md.

DATE OF BURIAL Jul 30 1922

20 UNDERTAKER David Gardiner

ADDRESS 86 Park

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 66380

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hosp. St.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wilson

(a) RESIDENCE. No. 1122 Ostend St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1921

7 AGE: Years 1 Months 1 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Samuel Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Viola Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant David Evans

(Address) 116 Ostend

15 Filed JUL 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to July 25, 1922, that I last saw him alive on July 25, 1922, and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid Examination

(Signed) Horace G. Stewart, M. D.

7/26, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. DATE OF BURIAL: July 30 1922

20 UNDERTAKER: D. and E. Evans ADDRESS: 116 Ostend

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66381

CERTIFICATE OF DEATH.

47 D 66381

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. Notre Dame Convent St.; 10 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Beatrice Weirich

(Residence in Baltimore: No. Linguite St. W. Lakeland Ave. St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, May 14, 1877 (Month) (Day) (Year)

7-AGE, 45 yrs. 2 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... 07

9-BIRTHPLACE, (State or Country), Rochester N.Y.

PARENTS.

10-NAME OF FATHER, Nicolaus Weirich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Augusta Gronaglet

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionysia

(Address) Notre Dame Linguite St

15- Filed JUL 30 1922, 191... ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 1921, to July 1922, that I saw h... alive on July 28 1922, and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma pleura, from Carcinoma of breast Operated Sept 1920

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. King M. D.

July 29, 191 22 (Address) 110 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Notch Cliff Md — DATE OF BURIAL, July 31, 1922

20-UNDERTAKER Frank A. Fink — ADDRESS 910 N. Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66382

CERTIFICATE OF DEATH.

164

D 66382

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 St Helena ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Welsh

(a) RESIDENCE. NO. 314 St Helena ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John Welsh

6 DATE OF BIRTH (month, day, and year) Aug 11 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Pesek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) James Doyle 1515 Christian st

15 Filed JUL 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to July 28, 1922

that I last saw h.r alive on July 27, 1922

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Johns Doyle, M. D.

, 19 (Address) 117 Balto ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL July 31 1922

20 UNDERTAKER Wendell Dippel & Son — ADDRESS 3[illegible]

BURIAL should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

66383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 66383

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 12 WARD)

2-FULL NAME Sarah Goldsborough

(a) RESIDENCE No. 2215 Hargrove Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 721

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, Municipal Hospital.

15 Filed JUL 30 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 19 22

17

I HEREBY CERTIFY, That I attended deceased from July 28, 19 22, to July 29, 19 22, that I last saw her alive on July 28, 19 22, and that death occurred, on the date stated above, at 12:45 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde Mitchell M. D.

7/29, 19 22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bellview Talbot Co

DATE OF BURIAL 7/31 19 22

20 UNDERTAKER W. A. Cook

ADDRESS 502 E Natl

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

Arlington 10 D 66384

REGISTERED No. C.....

D 66384

3-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5133 Main St and 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Mildred Keppler

(Residence in Baltimore: No. 5133 Main St and St.; 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept 21 (Month) (Day) 1918 (Year)

7-AGE: 3 yrs 10 mos 7 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: John Keppler

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Ethel A. Smith

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel A. Keppler

(Address) 5733 Main St

15- JUL 30 1922 Filed ..... 191 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 7 (Month) 29 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/19, 1922, to, 7/29, 1922, that I saw h[illegible] alive on 7/29, 1922, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Dephtheria

(Duration) yrs mos 10 ds.

Contributory (SECONDARY): Nephritis

(Duration) yrs mos 4-5 ds.

(Signed) Henry Russell M. D.

7/30, 1922 [Address] 3926 [illegible]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Western

DATE OF BURIAL: 7/31, 1922

20-UNDERTAKER: W M Cook

ADDRESS: 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66385

D 66385

CERTIFICATE OF DEATH.

179

19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; WARD)

2-FULL NAME Emory Green Mitchell

(a) RESIDENCE NO. 1808 W. Lombard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND) of or) WIFE of Mary V. Mitchell

6 DATE OF BIRTH (month, day, and year) July 3rd 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Retired) General 073

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Inspector for B and O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Perry G. Mitchell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Myra Ann Beckley

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Myra M. Hawkins (Address) 908 W. Fulton Ave.

15 JUL 30 1922 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 19 22

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 28, 1922,

that I last saw him alive on July 28, 1922

and that death occurred, on the date stated above, at 1.05A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 27, 22

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cox, M. D.

7/29/22, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL July 31 1922

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N. Bdwy

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 66386

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2534 Fait av. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Hruczak

(a) RESIDENCE NO. 2534 Fait av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 24 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: Walenty Hruczak.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Mary Wolk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Walenty Hruczak.

(Address) # 2534 Fait ave.

15 Filed JUL 30 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1922, to July 29, 1922.

that I last saw her alive on July 29, 1922;

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. days 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis Jump M. D.

July 29, 1922 (Address) 2431 Fait Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem.

DATE OF BURIAL: July 30, 1922

20 UNDERTAKER: M. J. Sadowski

ADDRESS: 905 S. Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66387

CERTIFICATE OF DEATH.

D 66387

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 Battery Ave. St.: 14 Ward)

2-FULL NAME. Anna Schneider

(a) RESIDENCE. No. 1440 Battery Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. Schneider

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Jos. Foldrauer

(Address) 1440 Battery Ave.

15 Filed JUL 30 1922 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) J. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from ——— 1918, to J. 28, 1922;

that I last saw her alive on J. 28, 1922;

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1438 William St.

Did an operation precede death? (Yes) Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Dr Filip B. Towler M. D.

J. 29, 1922 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Sepulcher — DATE OF BURIAL: 7/31 1922

20 UNDERTAKER: J. F. Eshenbrenner — ADDRESS: 1318 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

66388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66388

CERTIFICATE OF DEATH.

D 66388

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. St., 29 Ward)

2-FULL NAME William Henkett

(a) RESIDENCE. No. 321 Forest Road St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Virginia Henkett

6 DATE OF BIRTH (month, day, and year) July 3. 1859

7 AGE — Years: 63 — Months: — — Days: 13 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 0166

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: William Henkett

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1922, to July 29, 1922, that I last saw h. alive on July 29, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Tb peritonitis, vesiculitis and prostatitis.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary TB.

(duration) 3 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 4-11-22

Was there an autopsy? yes.

What test confirmed diagnosis? Gross findings

(Signed) Lucil H. Bagley, M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilson N. C.

DATE OF BURIAL: July 30 19 22

20 UNDERTAKER: H. E. Hughes.

ADDRESS: 424 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Blks.

66389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 7335
D 66389
1-PLACE OF DEATH

REGISTERED NO. D 66389

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph W. Folk.

(a) RESIDENCE. (No.) Tillman, S. Carolina (ST.) (WARD.)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Nonresident How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND) of ~~(or) WIFE of~~ G. W. Folk (Father)

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER George W. Folk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Ellen Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed JUL 31 1922, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1922 to July 29, 1922 that I last saw h~~im~~ alive on July 29, 1922 and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) yrs 6 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? S. Carolina

Did an operation precede death? Yes Date of July 29-1922

Was there an autopsy? Yes partial

What test confirmed diagnosis?

(Signed) Warfield M Iverson M. D.

7/30, 1922 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Scotia S. C.	July 30 1922
20 UNDERTAKER	ADDRESS
William G. Schaeffer	816 Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15 7193 D 66390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5-161-081 D 66390

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) (9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Leslie

(a) RESIDENCE. No. 228 N. High St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE of~~ Fred A. Leslie (Father)

6 DATE OF BIRTH (month, day, and year) July 9, 1922

7 AGE: Years ? Months ? Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Fred A. Leslie.

11 BIRTHPLACE OF FATHER (city or town) (State or country): London, England.

12 MAIDEN NAME OF MOTHER: Josephine Brodie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Atlanta, Ga.

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 31 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 29, 1922, that I last saw her alive on July 29, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J B Gay, M. D.

, 19 (Address) J H Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: July 31 1922

20 UNDERTAKER: Martin Fahey & Sons. ADDRESS: 1821 W North ave

IMPORTANT: Should be carefully examined. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 6639F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6639F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. St Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Mannion

(Residence in Baltimore: No. St. Agnes Hospital St.; yrs. 27 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Single

6-DATE OF BIRTH.

..... (Month) ..... (Day) 1888 (Year)

7-AGE. 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Orderly
(b) General nature of industry, business, or establishment in which employed (or employer): St Agnes Hospital

9-BIRTHPLACE. (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Michael Mannion

11-BIRTHPLACE OF FATHER. (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Katherine Farrell

13-BIRTHPLACE OF MOTHER. (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anne Mannion

(Address) 715 Reservoir St

15- ROBERT G. KRAUTER, Registrar.

Filed ..... 192.... Burial Permit Clerk.

JUL 31 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 28 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows.

Fracture of Skull
Fall from R.R. Bridge
& Street Accident

(Duration) ..... yrs mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs mos. ds.

(Signed) James H. Kenlon M. D. (Coroner)

July 29 1922 (Address) 760 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs ..... mos 1 ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? B & O R.R. & Eaton Co.

Former or usual residence St Agnes Hos.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Leakin Park Cem July 31 1922

20-UNDERTAKER. ADDRESS

Martin Hughes Son 1827 W North

Every effort should be made to secure information specified. In filling out this certificate, be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66392

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Nursery and Childs Hosp. ST. 19 WARD 8) REGISTERED NO 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Alfred Minke

(a) RESIDENCE. No. 213 Beall St. Cumberland, Md. ST. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ********

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ********

(c) Name of employer ********

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER William Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lonaconing Maryland.

12 MAIDEN NAME OF MOTHER Gertrude Minke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Maryland

11 Informant Gertrude Minke (Address) 216 Beall st Cumberland Md

15 Filed JUL 31 1922 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1922, to July 30, 1922, that I last saw him alive on July 29, 1922, 1 a.m. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion

(duration) 0 yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia terminal

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Cumberland Maryland

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 31 1922

20 UNDERTAKER: George F. Smith — ADDRESS: 1400-04 Fay St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118 / 07

D 66393

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1616 Druid Hill Av (St.) 14 WARD

(If death occurred in a hospital or institution give its NAME instead of street and number)

2-FULL NAME Marvin Houston Henderson

(a) RESIDENCE. No. 1616 Druid Hill Ave WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. 06. How long in U. S., if of foreign birth? yrs. mos. 35.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 26 21

7 AGE — Years: — Months: 14 Mar — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): 1616 Druid Hill Av Balto md

PARENTS

10 NAME OF FATHER: Frank Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Louise Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Frank Henderson

(Address): 1616 Druid Hill Ave

15 Filed JUL 31 1922, 19

Registrar

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28 1922 to July 30 1922

that I last saw h— alive on July 30 1922

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion and Bowel Stasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Parasitic Volvulus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? About

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Constipation-Abdominal Pain

(Signed) Chas. Norris M. D.

1922 Address: 1612 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: July 31 1922

20 UNDERTAKER: George T. A. Gilson

ADDRESS: 513 Fremont Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15743 7
D 66394

B/ D 66394

1-PLACE OF DEATH

REGISTERED NO

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lily Carpenter

(a) RESIDENCE No. 127 N. Ostend St. City ST.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Newborn yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Carpenter MOTHER

6 DATE OF BIRTH (month, day, and year): April 8, 1921.

7 AGE: Years 1 Months 3 Days 21. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): 5,000

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Richard Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Hattie Hines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: JOHNS HOPKINS HOSPITAL.

(Address): Record.

15 Filed JUL 31 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1922 to July 27 1922, that I last saw h[illegible] alive on July 27 1922, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous pneumonia

Miliary Tuberculosis

(duration) ..... yrs 2 mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home?

Did an operation precede death? — Date of —

Was there an autopsy? — No.

What test confirmed diagnosis? Tubercle bac. in sputum

(Signed) Redgley W Bass M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: July 28 1922

20 UNDERTAKER: Edward Taylor

ADDRESS: 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66395

CERTIFICATE OF DEATH.

D 66395

REGISTERED NO. 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7th St, E of 2nd Ave. ST., Fairfield WARD)

2-FULL NAME Maggie Burton

(a) RESIDENCE NO. 7th St. E of 2nd Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of Horace Burton

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Has not worked for 5 yrs.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Edle Co., N. C.

PARENTS

10 NAME OF FATHER David Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) X

14 Informant James Cunningham (Address) 7th St E 2nd Ave Fairfield

15 Filed JUL 31 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1922, to July 29, 1922, that I last saw he alive on July 28, 1922, and that death occurred, on the date stated above, at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

(duration) do not know yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. B. Davis M. D.

7/30, 1922 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch — DATE OF BURIAL July 30, 22

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Union

Green

66396

HEALTH DEPARTMENT—CITY OF BALTIMORE

66396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 653 Gay St. WARD) 17

REGISTERED No. C 112

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Green

(Residence in Baltimore: No. 653 Gay St.; yrs., mos. ds.) 45

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Unknown ....., 1877
(Month) (Day) (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Webb

(Address) 622 Gay St

15-

JUL 31 1922

ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Gastritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Klads M. D.
(Coroner)

July 31 22 (Address) 1437 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, July 31 1922

20-UNDERTAKER John H. Tregdin

ADDRESS 142 W. Lee St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66397

D 66397

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 S. Eight St. ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Veronica Gasser.

(a) RESIDENCE NO. 719 S. Eight St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): April 18-1922

7 AGE — Years: — Months: 3 Days: 11 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): No

(c) Name of employer: No

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William F. Gasser.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Nellie E. Mantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: William F. Gasser

(Address): 719 S. 8th St.

15 Filed JUL 31 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1922 to July 29, 1922

that I last saw her alive on July 29, 1922

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(duration) X yrs. X mos. 3 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. C. L. Truax M. D.

July 29, 1922 (Address) 248 E. 30 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: July 31 1922.

20 UNDERTAKER: Lilly and Zeiler ADDRESS: 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 W 111 D 66398

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Miller.

(Residence in Baltimore: No. 525 E. E. St. Sp. Point. St.; 7 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White.	Married.

6-DATE OF BIRTH, Sept. (Month) 18 (Day), 1877 (Year)

7-AGE, 44 yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber. 059
(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Miller

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mc Gowan

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Miller (Son)

(Address) 525 E. E. St Sp. Pt.

15- JUL 31 1922 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer. Rupture

(Duration) 1 yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Varicosities

(Duration) yrs. 7 mos. ds.

(Signed) Geo. Lotsion Yates M. D.
(Coroner)

July 30/22 (Address) 143 McElroy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	Aug. 1, 1922
20-UNDERTAKER Lilly & Zuber	ADDRESS 403 S. Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Webber ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

66399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2119 (St.) McClancy (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Webber

(a) RESIDENCE. No. 2119 McClancy St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

6a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 21st 1889

7 AGE: Years 32 Months 9 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jno A. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mrs Ella Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs S. Henkel

(Address) 2519 E Monument st

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-28-22

17 I HEREBY CERTIFY, That I attended deceased from March 4 1922 to July 28 1922

that I last saw h[illegible] alive on July 28 1922

and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Acute Edema of Lung

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) [illegible] M. D.

(Address) 1800 Hall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 31 1922
20 UNDERTAKER: Mrs Johannah Landes	ADDRESS 1004 Arisquith

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 N. Hope St., 9 WARD)

2-FULL NAME Jeanette Sullivan

(a) RESIDENCE NO. 1912 N. Hope ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
—	—	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jos. Sullivan Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lauretta Kernan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Jos. Sullivan Jr.
(Address) 1912 N. Hope st.

15 Filed JUL 31 1922 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1922, to July 28, 1922, that I last saw him alive on July 28, 1922 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Gastro-enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Bernbeck, M. D.

(Address) 1931 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hall's Cross Cemetery Hayford Road	7/31 1922
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Hayford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-2-19—H. P. Co.—1000 Bks.

D 66401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 66401

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Clarke

(a) RESIDENCE. No. 1616 N Gay ST ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): 10-27-21

7 AGE — Years: — Months: 9 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Charles Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Ambrosia Dermott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 31 1922 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to July 30, 1922, that I last saw her alive on 7-30, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Dysentery, Flexner

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stool Culture

(Signed) TB Gay, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 1 1922
20 UNDERTAKER	ADDRESS
George F. Ruth	735 Hanford Ave.

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 66402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66402

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 12 Harford ave St.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Margaret Connolly

(Residence in Baltimore: No. 2512 Harford ave St.; 60 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
67 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Connolly

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Holden

(Address) 2512 Harford ave

15- Filed JUL 31 1922 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1922 to July 28 1922, that I saw her alive on July 28 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart disease

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Thomas Whitridge M. D.

July 29 1922 (Address) 16 E Fayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
New Cathedral Cem.	Aug 1, 1922

20-UNDERTAKER	ADDRESS
Geo. J. Ruth	735 Harford ave

D 66403

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66403

CERTIFICATE OF DEATH.

Registered No. C 20179

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Carman

(Residence in Baltimore: No. 414 Rosedale Terrace St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

6-DATE OF BIRTH. Sept (Month) 18 (Day) 1915 (Year)

7-AGE. 6 yrs. 10 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Carroll J Carman

11-BIRTHPLACE OF FATHER, (State or Country) Balto Md.

12-MAIDEN NAME OF MOTHER, Mary A Hoover

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carroll J Carman

(Address) 414 Rosedale Ter

15 FILED JUL 31 1922 192

ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 30 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said decessed came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2° Burns Over Body
Acc. Burning Bldgs. Accidental
Came Unknown to
Mother (Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fulton M. D. (Coroner.)

July 30 1922 (Address) 70 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. 1/2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 414 Rosedale Terrace

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery DATE OF BURIAL. Aug. 1 1922

20-UNDERTAKER Wm. C. Blake ADDRESS 922 N Broadway

V

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66404

CERTIFICATE OF DEATH.

90 D 66404

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 441 E. 22 ST., 12 WARD)

2-FULL NAME Willie Eliza Spedden

(a) RESIDENCE NO. 441 E. 22nd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ White

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dawson Spedden

6 DATE OF BIRTH (month, day, and year) August 14, 1864

7 AGE Years 57 Months 11 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge (State or country) Md

PARENTS

10 NAME OF FATHER Robert Rawleigh

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Bradshaw

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Md.

14 Informant Louise Tedwinger. (Address) 471 E. 23rd St.

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to July 29, 1922

that I last saw her alive on July 29, 1922 and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Stomach

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Geo. M. Gimbel M. D.

July 27 1922 (Address) 743 E. Maryland Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md.

DATE OF BURIAL July 31 1922

20 UNDERTAKER Geo Jimelus & Son

ADDRESS 217 S. Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 66405

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66405

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Lessier. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Moody.

(a) RESIDENCE. NO. 701 Lessier ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	Colored,	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Thomas Moody.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Agnes Hollis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Agnes Moody
(Address) 701 Lessier St.

15 Filed JUL 31 1922

ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to July 30, 1922, that I last saw h alive on July 29, 1922, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis (Simple)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Chas. Uffenbodt, M. D.

, 19 (Address) 721 S. B'way.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL July 31 1922

20 UNDERTAKER Hamme Bros. ADDRESS 1364 Xeny

Duration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15/124 Paid D 66406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66406

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 113

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.: (Ward) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Robinson

(a) RESIDENCE. No. 101 N. Pulaski ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Robinson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Kordander

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 31 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1922, to July 24 1922, that I last saw him alive on July 24, 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
(Intestinal Intoxication acute)
Diarrhea not Dysentery
(duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) I B Grey, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Conn
DATE OF BURIAL 7/31 1922

20 UNDERTAKER Philip Herwig
ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

17419
D 66407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66407

CERTIFICATE OF DEATH.

173
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Hennard

(a) RESIDENCE No. 2112 W. Eutaw St. Balty WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

3a If married, widowed, or divorced
~~Husband of~~
(or) WIFE of Wm Hennard (Husband)

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Record

15 Filed JUL 31 1922 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to July 29, 1922, that I last saw h[illegible] alive on July 29, 1922, and that death occurred, on the date stated above, at 10:50 a. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis Cholecystitis. Empyema of Gall Bladder with perforation Local & diffuse peritonitis Myocarditis arteriosclerosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ....yrs. ....mos. 2 ds.?

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? O. & autopsy

(Signed) Edwin E Hart. M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bust cemetery — DATE OF BURIAL aug 2 1922

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIAN'S State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66408

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 66408

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin D. Hospital ST., 11 WARD)

2-FULL NAME Charles F. Kempton

(a) RESIDENCE NO. 224 W. Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Kempton

6 DATE OF BIRTH (month, day, and year) June 6, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49 yrs	1 mo	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 089

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER A. J. Kempton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Jennie McClenne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) R. I.

14 Informant Anna M. Kempton (Address) 224 W. Monument St.

15 JUL 31 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to July 25, 1922, that I last saw him alive on July 25, 1922 and that death occurred, on the date stated above, at 1400, m.

The CAUSE OF DEATH* was as follows:

Carcinoma of esophagus (upper third)

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Mal nutrition

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7/28/22

Was there an autopsy? Partial

What test confirmed diagnosis? Path. findings

(Signed) Lewis A. Pere, M. D.

(Address) 1 Franklin St. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 1 1922

20 UNDERTAKER Josiah Syfer — ADDRESS 160 W North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Boyle

D 66409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D 66409

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3574 Forest Park Ave. ST., WARD 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Boyle

(a) RESIDENCE NO. Sinai Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jack A. Boyle

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE Years 83 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elliott City Md

PARENTS

10 NAME OF FATHER Geo. A Hemmick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. H. C. Smith

(Address) 3420 Liberty Ave.

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1920, to July 29, 1922, that I last saw her alive on July 29, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Cerebral softening

decay (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Contracture of tendons

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Miller, M. D.

, 19 (Address) 1014 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md. DATE OF BURIAL Aug 1, 1922

20 UNDERTAKER George J. Smith ADDRESS 3425 Fayette St

INSTRUCTIONS.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Died at Southern Hosp.
Residence 3514 Forest
Was a patient at Park Ave
Spring Grove
Southern Hospital

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66410

CERTIFICATE OF DEATH

D 66410

1-PLACE OF DEATH

REGISTERED NO. 159

CITY OF BALTIMORE: No. 1802 N Montford ST. 8 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Foerster

(a) RESIDENCE. NO. 1802 N. Montford ST. 8 WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, 4 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Otto Foerster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Augusta Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Otto Foerster

(Address): 1802 N Montford ave

15 Filed JUL 31 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1922

17 I HEREBY CERTIFY That I attended deceased from July 31, 1922 to July 31, 1922

that I last saw her alive on July 31, 1922

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

8 month Foetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. H. Herzog M. D.

7/31, 1922 Address 1305 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: July 31 1922

20 UNDERTAKER: Robt E Lemmon Son — ADDRESS: N. Gay

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malformation heart.
Premature birth

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66411 (1) 174 D 66411

1 PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1532 E. Monument ST., 7 WARD)

2-FULL NAME Emily J. Craig

(a) RESIDENCE NO. 1532 E. Monument ST., WARD ....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1844.

7 AGE: Years 78 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: James Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Emma Rutledge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant: E. Patterson (Address) 1532 E Monument St

15 Filed JUL 31 1922 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1922, to July 30, 1922, that I last saw h[illegible] alive on July 30, 1922, and that death occurred, on the date stated above, at 2.25 p. m.

The CAUSE OF DEATH* was as follows:

Obstruction

Jaundice

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Fecal vomiting

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm H Arnett, M. D.

July 31, 1922 (Address) 701 N Eutaw Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery — DATE OF BURIAL: July 31. 1922

20 UNDERTAKER: Robt J Turner — ADDRESS: 7 E. Lexington St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66412

CERTIFICATE OF DEATH.

133D 66412

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1408 West Mulberry ST., WARD)

2-FULL NAME John T. Sapp

(a) RESIDENCE NO. 1408 West Mulberry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane M. Sapp

6 DATE OF BIRTH (month, day, and year): Feb. 12 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	18	

8 OCCUPATION OF DECEASED 030

(a) Trade, profession or particular kind of work: Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): (Stationary)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Sapp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Sarah A. Sitler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Eugene [illegible] Sapp

(Address): 1408 W. Mulberry St.

15 Filed JUL 31 1922 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30th 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to July 30, 1922,

that I last saw him alive on July 30, 1922,

and that death occurred, on the date stated above, at 11.40A m.

The CAUSE OF DEATH* was as follows:

Cystitis

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Bullamy Thomas, M. D.

7/30 19 22 (Address) 330 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Aug 1 19 22

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 W Baltimore St

N.B. Information required, when obtainable, must be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66413

CERTIFICATE OF DEATH

117 D 66413

REGISTERED NO.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No.) Madison & Linden ST.: (WARD) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Tillery.

(a) RESIDENCE. NO. 1344 Andre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 27 1917

7 AGE: Years 4 Months 11 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~—~~ None

(b) General natore of Industry, husiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Jos. Tillery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Christina Schneider

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto., Md.

14 Informant (Address): Jos. Tillery 1344 Andre St.

15 Filed , 19 Registrar

JUL 31 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to July 27, 1922, that I last saw her alive on July 27, 1922, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Acute Peritonitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 7/15/22

Was there an autopsy? No

What tests confirmed diagnosis?

(Signed) James Hulst Wilson, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 30 1922

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1419 Lights St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66414

1-PLACE OF DEATH 200 E. Barney St — 24 15 REGISTERED NO.

CITY OF BALTIMORE: (No.) ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E Scott

(a) RESIDENCE. No. 200 E. Barney ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
83				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Joseph E. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Morrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Howard Scott (Address) S Police St

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/29 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 20, 19 22 to July 29, 19 22

that I last saw h alive on July 29, 19 22

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Jaw

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 21-1922

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Frank S. Lyons, M. D.

7-29-1922 Address 141 W. Preston St. for 1140 Bennington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL August 1 19 22

20 UNDERTAKER Margaret E. Flynn ADDRESS 1422 Eutaw St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66415

CERTIFICATE OF DEATH.

101

D 66415

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 W. Lafayette Ave. ST., 16 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Mask.

(a) RESIDENCE NO. 1908 W. Lafayette Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 (Single, Married, Widowed, or Divorced; write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia A. Mask

6 DATE OF BIRTH (month, day, and year): January 7th, 1845

7 AGE — Years: 77 — Months: 6 — Days: 22 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles M. Mask

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Josephine Josse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): John M. Mask, 1908 W. Lafayette Ave

15 JUL 31 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29th, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1922, to July 29, 1922, that I last saw him alive on July 29, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marion A. Leech M. D.

July 30, 22 (Address) 5064 Belleau ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 1st. 1922

20 UNDERTAKER: Putnam & Gore — ADDRESS: 1723 W Lafayette

Spec.—1-10-21—M&T—1500 Bks.

D 66416 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66416

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Fulton Ave. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Merker

(a) RESIDENCE NO. 105 S. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of: Emma Merker

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm. Merker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Crofoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Emma Merker (Address) 105 S. Fulton Ave.

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922, to July 28, 1922, that I last saw him alive on July 28, 1922 and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Hypernephroma (Malignancy left kidney)

(duration) 1 yrs. 1 mos 22 ds.

CONTRIBUTORY (Secondary) Auto-intoxication Acidosis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Geo. J. Caplan, M. D.

7/31/22 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 8/1 1922

20 UNDERTAKER: Geo A. Farley

ADDRESS: 1800 W. Fayette

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66417

CERTIFICATE OF DEATH.

74-001 D 66417

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Brunt ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Chaney

(a) RESIDENCE NO. 2227 Brunt ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah J. Chaney

6 DATE OF BIRTH (month, day, and year) May 10th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Mr Peters

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER William Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Millie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Amelia Chaney (Address) 2118 Brunt St

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1922, to July 29th, 1922, that I last saw h[illegible] alive on July 29th, 1922, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E. Mackenzie M. D.

July 31, 1922 (Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon — DATE OF BURIAL July 1 1922

20 UNDERTAKER James A. Deems ADDRESS 1303 Pennsylvania

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66418

CERTIFICATE OF DEATH.

D 66418

118-003

1-PLACE OF DEATH

City of BALTIMORE: (No. Howard Hospital St. Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archie Lee Hammett

(Residence in Baltimore: No. 121 W. Virginia Ave St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Oct (Month) 1 (Day) 1890 (Year)

7-AGE. 31 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Furniture
(b) General nature of industry, business, or establishment in which employed (or employer): Mover

9-BIRTHPLACE, (State or Country). Calvert Co Md

PARENTS

10-NAME OF FATHER. Samuel J. Hammett

11-BIRTHPLACE OF FATHER, (State or Country). Charles Co Md

12-MAIDEN NAME OF MOTHER. Rosa E Bowen

13-BIRTHPLACE OF MOTHER, (State or Country). Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia M Hammett

(Address) 121 W. Virginia Ave.

15- JUL 31 1922 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 29 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Accidental Auto.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. E. Phillips M. D.
(Coroner.)

City (Address) 1 W. Mt. Royal Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem	July 31 1922
20-UNDERTAKER.	ADDRESS
John F. Denny	715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66419

CERTIFICATE OF DEATH.

74-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 N. Rose ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathew G. Hunter

(a) RESIDENCE NO. 1300 N. Rose ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary Hunter

6 DATE OF BIRTH (month, day, and year): Nov 13 1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Andrew Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Louis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Hunter

(Address): 130 N. Rose St.

15 Filed JUL 31 1922, 19

ROBERT N. KRAUSER, Burial Permit Clerk & Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1922 to July 29, 1922

that I last saw h[illegible] alive on July 28, 1922

and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W White M. D.

7/30, 1922 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Aug 1 1922 DATE OF BURIAL

20 UNDERTAKER: F Fink & Son ADDRESS Hay St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplexy.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66420

CERTIFICATE OF DEATH.

90 D 66420

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No.) ST., 19 (WARD)

2-FULL NAME Leona Johnson

(a) RESIDENCE NO. 307 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Johnson

6 DATE OF BIRTH (month, day, and year): March 1868

7 AGE: Years 54; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bayview Hospital Balto, Md.

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922 to July 28 1922 that I last saw her alive on July 28 1922 and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial (Mongolism)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) A. F. Edsmith M. D.

7/28 1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon

DATE OF BURIAL: July 31 1922

20 UNDERTAKER: Samuel Kinsley

ADDRESS: 578 W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66421

CERTIFICATE OF DEATH.

74-D 66421

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 307 S. Central Ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen T. Dunigan

(a) RESIDENCE. No. 307 S. Central Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeremiah Dunigan

6 DATE OF BIRTH (month, day, and year) Unknown 185?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Anna Belle Moan 307 S. Central Ave.

15 Filed JUL 31 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922 to July 28, 1922 that I last saw h[illegible] alive on July 28, 1922 and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Cardiopsis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A Valentine M. D.

(Address) 712 N Eutaw 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 1 1922

20 UNDERTAKER ADDRESS

Chas. F. Evans & Son 1180 W. Baltimore Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66422

CERTIFICATE OF DEATH.

31 D 66422

1-PLACE OF DEATH Calvert Court Apartments REGISTERED NO.

CITY OF BALTIMORE: No Calvert & 31st ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Wiegand

(a) RESIDENCE NO. Calvert & 31st ST. 3 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas F. Wiegand

6 DATE OF BIRTH (month, day, and year) Aug 8 - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Ruby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Kutcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas F. Wiegand (Address) Calvert & 31st Sts

15 Filed , 19 ROBERT R. KRAUTER, Registrar

JUL 31 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29" 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 29, 1922

that I last saw her alive on July 28, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam

(Signed) A. F. Costello, M. D.

, 19 (Address) 1335 E 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Aug 1" 1922

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 North Royal Ave

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66423 HEALTH DEPARTMENT—CITY OF BALTIMORE 44D 66423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Park Ave. ST., 14 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger W. Cull

(a) RESIDENCE No. 1415 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn White Cull

6 DATE OF BIRTH (month, day, and year) Aug. 7. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Atty. at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James Cull

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Sarah Cull Hume Adamstown Md.

15 Filed JUL 31 1922 ROBERT H. NEAL Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30.1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 19 22, to July 30, 19 22, that I last saw h alive on July 29, 19 22, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver & stomach & pancreas

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of July 17 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leon Friedman, M. D.

, 19 (Address) 1012 Cloud St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Frederick Md. DATE OF BURIAL August 1. 1922

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

66424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66424

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1702 N. Calvert St., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R. Feldeman.

(a) RESIDENCE NO. 1702 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 27 1859

7 AGE — Years: 63 — Months: 5 — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Lady 067

(b) General nature of industry, business, or establishment in which employed (or employer): Lycett (Stationery)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Richard E. Feldeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Deborah Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs C. F. Mitchell

(Address): 1702 N. Calvert St.

15 JUL 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 28th 1921, to July 30th 1922, that I last saw h alive on July 28th 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma, most likely of the left ovary & extended to the abdominal peritoneum

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Metastasis & exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Metastasis to peritoneum which was present during abdominal wall

(Signed) Saml V. Eberle, M. D.

, 19 (Address) 1431 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Aug 1 1922

20 UNDERTAKER: Chas E. Franck

ADDRESS: 802 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66425

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 N. Central Ave ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elenora E. Fales

(a) RESIDENCE NO. 826 N. Central Ave ST. 10 WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 2 1922

7 AGE — Years: — Months: 5 Days: 28 If LESS than 1 day, ...hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of Industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William L. Fales

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Minerva Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Minerva Fales

(Address): 826 N. Central Ave

JUL 31 1922

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1922

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1922, to July 30, 1922, that I last saw h[illegible] alive on July 30 1922 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Acute gastro enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of none

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) B. Fetherolf, M. D.

July 31, 1922 (Address) 1206 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: August 1 1922

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E Eager

WRITE PLAINLY, with unfading ink. This certificate must be filled out and signed before a permit for burial can be issued. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66426

CERTIFICATE OF DEATH.

114 D 66426

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 E Chase ST., 8 WARD)

2-FULL NAME Louisa Smith

(a) RESIDENCE NO. 1904 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 2 mos. 21 ds. How long in U. S., If of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Smith.

6 DATE OF BIRTH (month, day, and year) May 9 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Baldus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Vogelsinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Katie Smith

(Address) 1904 E Chase

15 Filed JUL 31 1922, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 19 22

17 I HEREBY CERTIFY, That I attended deceased from November 16, 19 21, to July 30, 19 22, that I last saw her alive on July 28, 19 22, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) — yrs. — mos. 30 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clark, M. D.

July 31, 1922 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	August 2, 1922
20 UNDERTAKER	ADDRESS
Henry Storck Son	130 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT IN FULL. Every question on this form should be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66427

CERTIFICATE OF DEATH.

D 66427

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 N. Regester ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Goedeke

(a) RESIDENCE NO. 1819 N. Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 9 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) God

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Aloysius H. Goedeke

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara M. Tragesser

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Aloysius H. Goedeke

(Address) 1819 N Regester St

15 Filed JUL 31 1922, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 19.., to July 31st, 19 22, that I last saw h... alive on July 30th, 19 22 and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Catarrh

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm S Love, M. D.

1301 E Eager St (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL August 1st 1922

20 UNDERTAKER Henry Horch Son — ADDRESS 1301 E Eager St

P. S.—WRITE PLAINLY WITH INK OR INDELIBLE PENCIL. ALL THE INFORMATION REQUESTED should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66428

CERTIFICATE OF DEATH.

3 D 66428

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Ensor ST., 10 WARD)

2-FULL NAME Thomas J. Radigan

(a) RESIDENCE No. 1001 Ensor ST., 10 WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Alice A. Radigan

6 DATE OF BIRTH (month, day, and year) May 23 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employed in 086

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Department

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. (State or country) Md.

PARENTS

10 NAME OF FATHER John J. Radigan

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna E. Doyle

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Alice A. Radigan

(Address) 1001 Ensor St

15 Filed 19 Robert P. Harrison Registrar

Burial Permit Clerk.

3 1 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1922

17 I HEREBY CERTIFY, That I attended deceased from 1-26, 1922, to 7-31, 1922, that I last saw him alive on 7-29, 1922 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos 2 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell M. D.

, 19 (Address) 152 N Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	August 2 1922
20 UNDERTAKER	ADDRESS
Henry Horck Son	1301 E Eagle

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66429

D 66429

CERTIFICATE OF DEATH.

12137

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 E.20th. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Oliver

(a) RESIDENCE. No. 216 E.20th. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 11, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 968

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Edith W. Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Sarah C. Coleman (Aunt)
(Address) 216 E.20th St.

15 Filed 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1922, to July 28, 1922, that I last saw her alive on July 28, 1922, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Cyst

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. L. Ingram, M. D.

7/31, 1922 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 1, 22
20 UNDERTAKER	ADDRESS
H.E. Hughes	434 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

L 3

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66430

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66430

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214- Caton Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM FRANKLIN MATHEWS

(a) RESIDENCE. No. 214 CATON AVE ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? ---- yrs. ---- mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
MALE	NEGRO	----

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 30th /22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---------

(b) General nature of industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer ---------

000

9 BIRTHPLACE (city or town) BALTIMORE
(State or country) MARYLAND

PARENTS

10 NAME OF FATHER Wm. H. MATHEWS

11 BIRTHPLACE OF FATHER (city or town) ####
(State or country) MARYLAND

12 MAIDEN NAME OF MOTHER LUCILLE JENKINS

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) MARYLAND

14 Informant LUCILLE MATHEWS
(Address) 214 CATON AVE

15 Filed ____, 19 1922 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JULY 30th 1922

17 I HEREBY CERTIFY, That I attended deceased from JULY 22 1922, to JULY 30th 1922, that I last saw h im alive on JULY 29th 1922, and that death occurred, on the date stated above, at 3.50 A m.

The CAUSE OF DEATH* was as follows:

CHOLERA INFANTUM

7-DAYS (duration) yrs. ---- mos. 7 ds.

CONTRIBUTORY (Secondary) ----------
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? --- Date of

Was there an autopsy? ---------

What test confirmed diagnosis? ---

(Signed) H. Franklin Schaul, M. D.

, 19 (Address) 102 N. Dallon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,
ADDRESS WOODALL. JUL 3 1922

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66431

CERTIFICATE OF DEATH.

D 66431

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2735 Hunterbury Ave. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Lillian Lewis

(a) RESIDENCE. No. 2735 Hunterbury Ave ~~ST.~~ 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White ~~Negro~~

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec 22nd 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Carrie Shanklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Carrie Lewis
(Address): 2735 Hunterbury Ave

15 Filed 19 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31st 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28 1922 to July 31 1922

that I last saw h alive on July 30 1922

and that death occurred, on the date stated above, at 2.45 m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms —

(Signed) R B Norment M. D.

7.31 1922 Address 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Hall. Balto Co	Aug 1st 1922

20 UNDERTAKER: Mrs. J. W. Dwight & Son ADDRESS: 50 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 66432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66432

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Payson and Poplar Grove St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Snyder

(Residence in Baltimore: No. 802 Dukeland St. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1..... (Year)

7-AGE: About 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of Industry, business, or establishment in which employed (or employer) Home Work

9-BIRTHPLACE (State or Country): Frederick Co Md.

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER, (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER, (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A M. Snyder

(Address) 1714 Appleton St.

15-

Filed 1922 Robert F. Harrison, Registrar.

Asst. Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Mouth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

..... 192 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Mt Olivet Cem July 31 1922

20-UNDERTAKER. ADDRESS
William Cook 503 E. Fort Ave

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66433 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 66433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hosp. REGISTERED NO. 100

CITY OF BALTIMORE: (No. 18 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Toole

(a) RESIDENCE No. 1036 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know

6 DATE OF BIRTH (month, day, and year) Aug 13-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm. R. Gibson (Address) 1036 Hollins St.

15 Filed Jy 31 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/22 19

17 I HEREBY CERTIFY, That I attended deceased from 7/30/22, 19 , to 7/31/22, 19 .

that I last saw h alive on 7/31/22, 19

and that death occurred, on the date stated above, at 12.20 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Nephritis Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Primary Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. C. Caldwell M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National cemetery DATE OF BURIAL 8/2 192

20 UNDERTAKER William Cook ADDRESS 502 E Hoff

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66434

D 66434

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) 210 Lawrence ST.: (Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Romaine E. Crudorf

(a) RESIDENCE. NO. 210 Lawrence ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occ[illegible] 4 mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benj Shillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Harriet Sandy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Christine Mullen

(Address) 2[illegible] Lawrence St.

15 Filed JUL 31 1922 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 16th, 1921, to July 30th, 1922, that I last saw h[illegible] alive on July 30th, 1922, and that death occurred, on the date stated above, at 11.0 P.M. (a.m.)

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Jones, M. D.

(Address) 720 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Aug 1922

20 UNDERTAKER [illegible] — ADDRESS [illegible]

INSTRUCTIONS: Please write plainly with pen and ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66435

CERTIFICATE OF DEATH.

D 66435

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: NO. Holkens Ave. ST. 7C WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. McDaniel

(a) RESIDENCE NO. Halethorpe, Md ST. WARD Halethorpe Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1842

7 AGE Years 80 yrs. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumbing

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John McDaniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Cecilia Shriner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Fred. Myerly (Address) 702-24 Ave.

15 Filed Robert F. Harrison, Registrar

1-1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-11 1920 to 7-31 1922

that I last saw ~~him~~ alive on 7-31 1922

and that death occurred, on the date stated above, at 12 3/4 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis -

(1) pneumonia -

~~(2) Hypostatic~~ carditis -

several (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure pneumonia 5 days (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) W. C. Caldwell M. D.

7-31 1922 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

DATE OF BURIAL Aug. 2nd 1922

UNDERTAKER Joseph L. Cook

ADDRESS 1003 N. Eutaw St

MARYLAND LAW REQUIRES THAT ALL ENTRIES ON THIS CERTIFICATE SHALL BE MADE WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66436

CERTIFICATE OF DEATH.

X 74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2129 McCulloh ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert DeNeal

(a) RESIDENCE. No. 2911 Dumbarton Ave. N.W. WARD. Washington D.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed or divorced HUSBAND of Annie F. ~~Julia~~ DeNeal

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Decorating

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John DeNeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Cecil DeNeal (Address) 609 Pitcher

15 Filed AUG 1 1922 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1922, to July 31, 1922, that I last saw him alive on July 31, 1922, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. (?) 1 mos. ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ———

(Signed) H. S. McCard, M. D.

7/31, 1922 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington DC — DATE OF BURIAL 7-31 1922

20 UNDERTAKER George T. A. Gibson — ADDRESS 518 F[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66437

D 66437

CERTIFICATE OF DEATH.

96

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 207 N. Ellwood ave ST., 6 WARD)

2-FULL NAME Rose Mahon Giles

(a) RESIDENCE NO. 207 N. Ellwood ave ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Giles

6 DATE OF BIRTH (month, day, and year): Mar. 27 1844

7 AGE — Years: 77 — Months: 8 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Kerns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Denny Mahon 207 N. Ellwood Ave

15 Filed 1922 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 29, 1922, that I last saw h[illegible] alive on July 28, 1922, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pescaprè M. D.

July 31, 1922 (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: 8/11 1922

20 UNDERTAKER: J. A. Moran — ADDRESS 300 E. Baltimore

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66438

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 604 Glendalen Ave (ST.) (16 WARD)

2-FULL NAME Jno. A. Knell

(a) RESIDENCE. NO. 604 Glendalen Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND (~~or WIFE~~) of Mrs. Margaret Knell

6 DATE OF BIRTH (month, day, and year) Sept 5

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51.	0	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cheese Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Andrew Knell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Feghner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Knell (Address) 1729 W. Pratt St.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1922, to ~~July 30~~ July 30 1922 that I last saw h~~im~~ alive on July 30 1922 and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cancer Cardiac and Stomach

(duration) yrs. 3 mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Signed Howard Kelly M. D.

7/31 1922 Address 2027 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: July 3 1922

20 UNDERTAKER: Knell & Son — ADDRESS: 1729 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 66439

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66439

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7th st near George Town Rd ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John George Stonnsky

(Residence in Baltimore: No. 7th st. near George Town Road St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Single

6-DATE OF BIRTH, ... July (Month) 28 (Day), 1922 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 6 mos. 3 ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, August Stonnsky

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amelia Luber

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Stonnsky

(Address) Idlewild Park

15-

Filed AUG 1 1922, 191... ROBERT R. KRAUTER Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1922, to July 30 1922, that I saw him alive on July 30 1922, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver
Entero Colitis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Howard B. Hale M. D.

....., 191... (Address) Stadium

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Aug 1, 1922
20-UNDERTAKER	ADDRESS
Mc. Mc. & S. Bros	1737 W. Pratt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15716. D 66440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X163 D 66440

D 66440

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL (WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Riderwood.

(a) RESIDENCE. No. Masonic Bldg Towson, Md ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced (HUSBAND of) (or) (WIFE of): Marion Gibson. (Red Cross Nurse)

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years ? Months ? Days 14? If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chief. Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed AUG 1 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to July 29, 1922, that I last saw him alive on July 29, 1922, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

BVW

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary): Multiple abscesses

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-21-22

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) A A Meech, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick's

DATE OF BURIAL: Aug 1 1922

20 UNDERTAKER: Wm Wm A. S'Pinty

ADDRESS: 1787 N Gay St

4

X. B.—BLANKS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lack of care.
Baby found.
Neglect.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6644 | CERTIFICATE OF DEATH. | 1922 D 6644

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1103 S Carey Ward) 21

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E Lilly

(Residence in Baltimore: No. 1103 S Carey St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. Oct (Month) 12 (Day) 1873 (Year)

7-AGE. 48 yrs. 9 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer 030
(b) General nature of industry, business, or establishment in which employed (or employer): Walker Jr Plant

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER. Francis Lilly

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Virginia Cat

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cecilia Lilly

(Address) 1103 S Carey St

15- FILED AUG 1 - 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 28 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound through Frontal Cord at 3 Cervical Vertebrae Homicide

(Duration) ....yrs. ....mos. ½ ds

CONTRIBUTORY (Secondary) Hemorrhage

(Duration) ....yrs. ....mos. ....ds

(Signed) James J. Mc Lenahan M. D. (Coroner.)

July 31 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos. ½ ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 1103 S Carey St

Former or usual residence. ! ! ! !

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Aug 1 1922
20-UNDERTAKER.	ADDRESS.
Jas Joerdens & Son	217 S. Paca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Linnenbom

D 66442

CERTIFICATE OF DEATH.

47 D 66442

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Scott St. ST.; 21 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine M Linnenbom

(Residence in Baltimore: No. 803 Scott St. St.; 70 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 12, 1848 (Month) (Day) (Year)

7-AGE, 74 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Klaus

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A Linnenbom

(Address) 803 Scott St

15- AUG 1 = 1922 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7 1922, to July 31 1922 that I saw her alive on July 25 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 7 ds.

(Signed) J. M. Linnemann M. D.

July 31, 1922 (Address) 826 N. Curtis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, July 2, 1922

20-UNDERTAKER Pulliam Bach ADDRESS 502 E Mt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66443

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.) St. Agnes Hospital

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mary ST., 28 (WARD)

2-FULL NAME Mrs. Alice Cann.

(a) RESIDENCE NO. 4401 Pentwyne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. B. Cann

6 DATE OF BIRTH (month, day, and year): Aug 27 62

7 AGE: Years 5-4 yrs. Months 11 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Charles McElroy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md.

12 MAIDEN NAME OF MOTHER: DeBere

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Bertram B Cann (Address) 4401 Pentwyne ave

15 Filed AUG 1 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 19

17 I HEREBY CERTIFY, That I attended deceased from July 12 19 to July 22 19

that I last saw h alive on July 22 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows

Carcinoma Uteri

Pneumonia Contus

& Fever

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 12

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. Blandford, M. D.

19 (Address) 1 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Londontown Cemetery — DATE OF BURIAL: Aug 1 19 22

20 UNDERTAKER: W M Routson — ADDRESS: 223 N Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66444 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66444

CERTIFICATE OF DEATH. 1922 No. 17950

1-PLACE OF DEATH

City of BALTIMORE: (No. 218 N Caswell Av St. 5 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Gloria

(Residence in Baltimore: No. 218 N Caswell Av St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	

6-DATE OF BIRTH.

..... 1 .....
(Month) (Day) (Year)

7-AGE. Possibly Jan 1

.....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Simon Madrid

11-BIRTHPLACE OF FATHER, (State or Country). Cuba

12-MAIDEN NAME OF MOTHER. Mabel Miles

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Filed AUG 1-1922 19.. Robert P. Harrison, Registrar.

JUL 31 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows

1. Pneumonia Lobar
2.
3.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos ds.

(Signed) M. D.
(Coroner.)

....., 19.. (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs mos ds In the State yrs mos ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ... 19..

20-UNDERTAKER. ADDRESS

JUL

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66445

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 111-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 S. Carlton ST.; WARD)

2-FULL NAME Lula Worden

(a) RESIDENCE. No. 4 S. Carlton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife

6 DATE OF BIRTH (month, day, and year) Nov 1894

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pikesville Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Emma Sims

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Wm Worden
(Address) 4 S. Carlton st

15 AUG 1-1922 ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1922

17

I HEREBY CERTIFY, That I attended deceased from June 9 1922 to July 29 1922

that I last saw her alive on July 29 1922

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows

Ulcer stomach

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank E. Traynor M. D.

8/1, 1922 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Interment Pentas	aug 1 1922

20 UNDERTAKER ADDRESS

J. H. Woodcock 426 Edmondson

INSTRUCTIONS: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 66446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66446

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 729 S Chapel ST.: 2 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis C Wacker.

(a) RESIDENCE. No. 229 S Chapel ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margreth Wacker.

6 DATE OF BIRTH (month, day, and year) Nov. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coffee Roaster

(b) General nature of industry, business, or establishment in which employed (or employer) Covering 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Wacker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Elizabeth Kerlside

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frederick Wacker.

(Address) 232 S Chapel St.

15 Filed AUG 1-1922 . 19

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from March 19 . 1922 to July 31 . 1922

that I last saw him alive on July 29 . 1922

and that death occurred, on the date stated above, at 10 55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Senorshage.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo D Dieyacks, M. D.

. 19 (Address) 288 S Patto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Aug 3 1922
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2060 Eastern Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66447

CERTIFICATE OF DEATH. 6

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1904 E. Fayette ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Roeder

(a) RESIDENCE NO. 1904 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 5 mos. 13 ds. How long in U. S., if of foreign b— yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M. Roeder

6 DATE OF BIRTH (month, day, and year): Feb 16 1866

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
56	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer 061

(b) General nature of industry, business, or establishment in which employed (or employer): Curtis Bay

(c) Name of employer: Walk

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Samuel T. Roeder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germ

12 MAIDEN NAME OF MOTHER: Rachel Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant (Address): Anna M. Roeder 1904 E. Fayette

15 Filed AUG 1 1922, 19 H. Wahn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1922, to July 28, 19 22

that I last saw h— alive on July 26, 19 22

and that death occurred, on the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Tumor of Brain (Cerebral)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Coma - (Compression)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Wm. A. Brumm, M. D.

, 19 (Address) 1254 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: July 31 19 22

20 UNDERTAKER: H. Eichner & Co.

ADDRESS: Fair Hill

Spec.—1-10-21—M&T—1500 Bks.

D 66448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66448

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Veterans' Hospital #56 Fort McHenry Md.

CITY OF BALTIMORE: (No. ST., 18 WARD)

2-FULL NAME Will Cannon

(a) RESIDENCE NO. 1020 W. Lexington St. Balto St., Md. WARD 39
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25 Yr.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) ------

(c) Name of employer ------

9 BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital records Fort McHenry Md.

15 Filed AUG 1-1922, 19 J E Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1922 to July 29, 1922, that I last saw him alive on July 29, 1922, and that death occurred, on the date stated above, at 11'40 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic Pulmonary Far advanced & active.

----- (duration) - yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Pneumothorax (left)

(duration) -- yrs. - mos. -- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. reports

(Signed) W D Lusk Surgeon (R), M. D.

7/29 1922 (Address) US.V. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL July 31 1922

20 UNDERTAKER S. Leuzon & Bro

ADDRESS 1117 E Balto

N. B.—WHITE PAPER, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66449

CERTIFICATE OF DEATH.

90 D 66449

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 731 Greenmount Ave ST.; 10 (WARD)

2-FULL NAME Mrs. Sarah E. Hilton

(a) RESIDENCE. (Usual place of abode) NO. 731 Greenmount Ave ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W	Widow

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of John E. Hilton

6 DATE OF BIRTH (month, day, and year) Sept 25, 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ~~None~~ 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Wm Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER — Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Henry Hienmiller

(Address) 731 Greenmount Ave

15 Filed ..... 19 .....

AUG 1-1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to July 31, 1922, that I last saw h[illegible] alive on July 31, 1922, and that death occurred, on the date stated above, at 10.35 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein, M. D.

8/1/, 1922 (Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	Aug 1 1922

20 UNDERTAKER Jno Jenkins & Sons F. P. Pace

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66450

CERTIFICATE OF DEATH.

113 D 66450

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1521 School ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Johnson

(a) RESIDENCE. No. 1521 School ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Harriet Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Daniel Johnson 1521 School St

15 Filed AUG 1-1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1922, to July 31, 1922

That I last saw h— alive on July 31, 1922

and that death occurred, on the date stated above, at 12.15 p m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Food Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Frequent Stools

(Signed) Chas Short, M. D.

7/31 1922 Address 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Aug 1 1922

Mt Auburn.

20 UNDERTAKER James A. Dennis ADDRESS 1303 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

(Andrzejewska) ✓

157357
D 66451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 66451

1-PLACE OF DEATH

REGISTERED NO. 1

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Andrzejewska.

(a) RESIDENCE No. 2631 Boston St. City ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of (Name) Philip & Lillian Andrzejewska

6 DATE OF BIRTH (month, day, and year) Jan. 31, 1922.

7 AGE: Years — Months 7 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Philip Andrzejewska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland.

12 MAIDEN NAME OF MOTHER Lillian Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed AUG 1 - 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1922. to July 30, 1922.

that I last saw her alive on July 30, 1922.

and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Xray

(Signed) T B Gay, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery — DATE OF BURIAL: Aug 1922

20 UNDERTAKER: Stephen J Fralkowski — ADDRESS: 1003 Kenyon Ave

N. B.—WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66452

CERTIFICATE OF DEATH.

D 66452

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1116 S Kenwood Ave. 1 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony A Phillips

(a) RESIDENCE. No. 1116 S Kenwood Ave. 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md USA

PARENTS

10 NAME OF FATHER Anthony Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary Kruzla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md USA

14 Informant Mary Phillips
(Address) 1116 S Kenwood Ave

15 Filed AUG 1-1922 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1922, to July 31, 1922, that I last saw h[im] alive on July 31, 1922 and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo colitis
complicated by convulsions

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Manuel S Tennis, M. D.

, 19 (Address) 3325 Park Pl. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 2 1922
20 UNDERTAKER	ADDRESS
Stephen J Fiedkowski	1005 Kenwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66453

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital 16 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Gibson

(Residence in Baltimore: No. 1705 Eutaw St.; yrs. 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. 1885 Dont Know 1
(Month) (Day) (Year)

7-AGE. 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Gibson

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Gibson

(Address) 1705 Eutaw Court

15-

Filed AUG 1-1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29- 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto - Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Geo Elliott Mayo M. D.
(Coroner)

1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Aug 1st 1922

20-UNDERTAKER, J. Fowler ADDRESS 272 Linden Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118 D 66454

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Calvert & Saratoga STS (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Anunciata Yetzer

(a) RESIDENCE NO. 110 E. West. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 15, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Sisters of Holy Cross.

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Jos. Yetzer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Cath. Kemps

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Sr. Pulphilia Smead

(Address) 116 E. West St.

15 Filed AUG 1 1922, 19

H. Welsh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1922, to July 30, 1922, that I last saw her alive on July 30, 1922, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 29/22

Was there an autopsy?

What test confirmed diagnosis? Operation.

(Signed) Daniel J Dessagno, M. D.

.. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A & C.

DATE OF BURIAL: 8-2 1922

20 UNDERTAKER: E & B Hall

ADDRESS: 115 E West St

WHITE PENCIL, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66455

CERTIFICATE OF DEATH.

113

D 66455

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 S. Third St. ST., N WARD)

2-FULL NAME Anna K. Zeller.

(a) RESIDENCE NO. 739 S. Third St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Robert F. Zeller

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Beatrice McAdams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Robert F. Zeller

(Address) 739 S. Third St

15 Filed , 19 ROBERT R. KNAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1922

17

I HEREBY CERTIFY, That I attended deceased from July 27th, 19 , to July 31st, 1922.

that I last saw her alive on July 30th, 1922.

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Burke, M. D.

19 (Address) 3042 Hudson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Aug 1 1922

20 UNDERTAKER Lilly & Zeller

ADDRESS 403 S. Mon St

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66456

Spec.—1-10-21—M&T—1500 Bks.

D 66456 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Edmondson Ave ST., 13 WARD)

2-FULL NAME Baby Jennings

(a) RESIDENCE NO. 714 Gingie Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Baby Girl 3 hours

7 AGE Years Months Days If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Omer Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Martha Meemore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Martha Jennings.

(Address) 714 Gingie Ave city.

15 Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-1 1922.

17 I HEREBY CERTIFY, That I attended deceased from 8-1-, 1922, to 8-1-, 1922

that I last saw her alive on 8-1-, 1922

and that death occurred, on the date stated above, at 4 45 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Caldwell M. D.

Aug 1 1922 (Address) 1 Wagner Court

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Aug 1 1922

20 UNDERTAKER Ehrenwerths Son — ADDRESS Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66457

CERTIFICATE OF DEATH.

91-00 D 66457

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Vincent

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE — Years: 80 — Months: -- — Days: -- — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, Municipal Hospital.

15 Filed AUG 1 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 19 22

17

I HEREBY CERTIFY, That I attended deceased from July 28 .19 22. to July 28 .19 22.

that I last saw her alive on July 28 .19 22.

and that death occurred, on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) senility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde O'Neill M. D.

7/29/23 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL

20 UNDERTAKER: Communicable Health,

ADDRESS 19 1922 AUG 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66458

D 66458

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Jackons wharf foot Caroline St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benj Bayline

(Residence in Baltimore: No. Bay West St.; yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Unknown

6-DATE OF BIRTH. Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. about 65 yrs mos. ds.

If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE. (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Balto

15- Filed AUG 1 - 1922 192.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, ... find that said deceased came to his death (Autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Horton M. D.

July 31 1922 (Coroner) (Address) Curtis Bay Balto. Md

*State the Disease Causing Death, or, if death resulted from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the state..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

UNIVERSITY OF MARYLAND 192

20-UNDERTAKER. ADDRESS

Commissioner Health, AUG 1 - 1922

THE MORGUE. 1910

For Wm F. WOODALE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66459 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-601

D 66459

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 9 WARD)

2-FULL NAME Mr John Selig

(a) RESIDENCE. No. 2103 E. North ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1875

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
46	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Selb Bavaria

PARENTS

10 NAME OF FATHER Adam Selig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER Mary C. Brehm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Mary C Lehn
(Address) 2103 E North ave

15 Filed AUG 1 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to July 30, 1922, that I last saw him alive on July 30, 1922, and that death occurred, on the date stated above, at 5.08 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) [redacted] (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 27, 1922

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy Findings.

(Signed) Ernest Edlavitch M. D.

7/30, 1922 Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: E. J. Oakland Cemetery E. O. Fanning & Son

DATE OF BURIAL: Aug 2 1922

20 UNDERTAKER: E. O. Fanning & Son

ADDRESS: 1938 E Lafayette Ave.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66460

CERTIFICATE OF DEATH

X 179 D 66460

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 908 Dukeland Ave St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary E. Simons

(Residence in Baltimore: No. 908 Dukeland Ave St.: yrs. 1 mos. ds.)

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7 AGE: About 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer): Domestic Duties 037

9 BIRTHPLACE (State or country): Va Virginia

PARENTS

10 NAME OF FATHER: Joseph Bogent

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph V. Simons

(Address) Catonsville, Md.

15 AUG 1-1922 191

ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: ~~July~~ July 30, 1912 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18th, 1922, to July 30th 1922 that I saw h[illegible] alive on July 29th, 1922 and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 10 yrs. — mos. — ds

Contributory (SECONDARY) Dementia.

(Duration) 3 yrs. — mos. — ds.

(Signed) H. O. Grunt M. D.

7/31, 1922 (Address) 1207 Poplar Grove

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Catonsville

19 PLACE OF BURIAL OR REMOVAL: Oella Sem

DATE OF BURIAL: July 31, 1922

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

Spec.—1-10-21—M&T—1500 Bks.

D 66461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66461

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1628 N. Smallwood ST., 15 WARD)

2-FULL NAME Bernard Wolfson

(a) RESIDENCE No. 1628 N. Smallwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. 1 mos. 15 ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 17/22

7 AGE — Years: — Months: 1 — Days: 15 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none off

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. md.

PARENTS

10 NAME OF FATHER: Harry Wolfson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Julia Glassman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Harry Wolfson 1628 N. Smallwood

15 Filed AUG 1 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/31 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/30 1922 to 7/31 1922, that I last saw him alive on 7/31 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1628 N. Smallwood

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Stalberg M. D.

1922 (Address) 2210 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL: July 1, 1922

20 UNDERTAKER: A. Simson & Bro — ADDRESS: 1127 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

D 66462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66462

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE (No. Wilkens Ave. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Kauffman.

(a) RESIDENCE NO. 2417 N. Baker St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ ~~Married~~ ~~Widowed~~ ~~or Divorced~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada Kauffman

6 DATE OF BIRTH (month, day, and year): Dec 2-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48 yrs	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " " "

12 MAIDEN NAME OF MOTHER: " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " " "

14 Informant: David Kauffman

(Address) 2417 N. Baker St.

15 Filed AUG 1-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-1 1922.

17 I HEREBY CERTIFY, That I attended deceased from 7-26-, 1922, to 8-1-, 1922, that I last saw him alive on 8-1-, 1922, and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue with metastases to glands both sides of neck, lungs and liver.

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock.-Cardiac failure, Pulmonary oedema. (duration) yrs. mos. 12 hrs. dys.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of 7-31-22.

Was there an autopsy? No.

What test confirmed diagnosis? Operation & Micro.

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 8/3 1922

20 UNDERTAKER: Wm. Cook

ADDRESS: 507 E. North ave.

D 66463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 611 N. Bond St. 7 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph Kintzing

(Residence in Baltimore: No. 611 N. Bond St.; yrs. 32 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. February (Month) 19 (Day) 1884 (Year)

7-AGE. 38 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Railroad

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Philip Kintzing

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Marie Hines

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Nordorft

(Address) 424 E. 20th St.

15- Filed AUG 1-1922 192.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 31 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Contributory Carcinoma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

192.... (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	August 3 1922
20-UNDERTAKER,	ADDRESS
H. Sanders Sons	1710 Eutaw St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66464

161-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 811 Calhoun ST.: 16 WARD)

2-FULL NAME Carroll Parker

(a) RESIDENCE. NO. 811 Calhoun ST.,

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 28 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto- md.

PARENTS

10 NAME OF FATHER Obeden Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Vernal Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lydia Parker

(Address) 811 Calhoun St.

15 Filed 1-1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1922, to July 31, 1922.

that I last saw h[illegible] alive on July 29, 1922.

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) not being developed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos J Woolridge, M. D.

7/3, 1922 (Address) 705 W Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn	Aug 1 19
20 UNDERTAKER	ADDRESS
Joseph L Harrold	[illegible]

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS shall state

US

Dr Glassman 743 W Hayetto

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66465

CERTIFICATE OF DEATH.

118,001 D 66465

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 W. Baltimore St., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Mc Farland

(a) RESIDENCE NO 618 W. Balto ST., 4 WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Mc Farland

6 DATE OF BIRTH (month, day, and year) Feb. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER John H. Mc Farland

11 BIRTHPLACE OF FATHER (city or town) Baltimore City (State or country)

12 MAIDEN NAME OF MOTHER Ann Alson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore City (State or country)

14 Informant Mary H. Mc Farland (Address) 618 W. Balto St.

15 8-1-1922 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to July 30, 1922

and I last saw h alive on July 30, 1922

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

, 19 (Address) 2687 Presbury Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral Cem DATE OF BURIAL 8/2 1922

20 UNDERTAKER J. J. Moran ADDRESS 2000 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Exact information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 533 Bentalou ST., (WARD) 20

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry King

(a) RESIDENCE No. 533 Bentalou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie King.

6 DATE OF BIRTH (month, day, and year): Dec. 18 1857

7 AGE: Years 65 | Months 7 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hair hacker.

(b) General nature of industry, business, or establishment in which employed (or employer): Mattress Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: John King.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Mollie King. (same)

15 Filed 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1922, to July 31, 1922,

that I last saw h[illegible] alive on July 31, 1922,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia.

Arterio-sclerosis.

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis of

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Bowe, M. D.

19 (Address) 904 N. Charles.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 1922

20 UNDERTAKER: K B Hyppe — ADDRESS: 22-36 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every effort should be made to obtain and furnish information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of causo of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic. Secondary cerebral hemorrhage.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66467

D 66467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital 25 31

CITY OF BALTIMORE (No. Fulton Ave. St. ... Ward)

REGISTERED NO. ...

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Susanna Morehead

(a) RESIDENCE No. St. Agnes Hospital St., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Albany, N. Y.

PARENTS

10 NAME OF FATHER David Morehead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Haley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Harriet Morehead (Address) 36 White St. Saratoga

15 Robert P. Harrison, M. D. 19 Registrar

1-1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31 1922.

17 I HEREBY CERTIFY, That I attended deceased from 2-29, 1920, to 7-31, 1922.

that I last saw h[illegible] alive on 7-31, 1922.

and that death occurred, on the date stated above, at 11 20 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculin T. Natta

Antitoxin

(duration) 4 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ... Not known

Did an operation precede death? ... Date of ...

Was there an autopsy? ... No

What test confirmed diagnosis? ... Clinical

(Signed) ... M. D.

... 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leatherbed Cem

DATE OF BURIAL Aug 1 1922

20 UNDERTAKER [illegible]

ADDRESS [illegible] North

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this certificate should be answered. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 66468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66468

CERTIFICATE OF DEATH.

X 113

1-PLACE OF DEATH St. V. d. P. REGISTERED NO.

CITY OF BALTIMORE: (No. 1401, Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wengel

(a) RESIDENCE NO. 1401 Division St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov. 9, 192[illegible]

7 AGE: Years — Months: 8 — Days: 21 — If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cumberland Maryland

PARENTS

10 NAME OF FATHER: George Wengel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Elizabeth Fickler

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: St. Vincent Infant Asylum

(Address) 1401 Division St

15 Filed 1-19-1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1922, to July 30, 1922,

that I last saw him alive on July 30, 1922

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus —

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Dysentery —

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. R. Fackbornes —, M. D.

19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: July 1922

20 UNDERTAKER: Martin Fraley-Elson

ADDRESS 1527 W North Ave

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 1-1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Diarrhoea + Enteritis

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66469

CERTIFICATE OF DEATH.

113 D 66469

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3049 Stafford ST 20 WARD)

If death occurred in a hospital or institution, give its NAME instead of street and number

2-FULL NAME Edna C. Bentelspacher

(a) RESIDENCE NO. 3049 Stafford ST WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 1st 1922

7 AGE: Years — Months 6 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Bentelspacher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Edna Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Wm Bentelspacher (Address) 3049 Stafford St

15 1-1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1922

17 I HEREBY CERTIFY That I attended deceased from July 17 1922 to July 31 1922

that I last saw h alive on July 29 1922,

and that death occurred on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Zitnick M. D.

Aug 1 1922 (Address) 2151 Whitelock ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery DATE OF BURIAL: Aug 2nd 1922

20 UNDERTAKER: H B Heppert ADDRESS: 2256 Fredk Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

S. —1-10-21—M&T—1500 Bl[illegible]

D 66470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1603

18 D 66470.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1316 W. Baltimore ST., 19 WARD)

2-FULL NAME Robert E. Roelke

(a) RESIDENCE NO. 1316 W. Baltimore ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26, 04

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Pa

PARENTS

10 NAME OF FATHER Geo W Roelke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caldwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Geo W Roelke
(Address) 1316 W Balto St

15 Filed 1-1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY That I attended deceased from Feb. 10. 1922. to July 31. 1922.
that I last saw him alive on July 30. 1922.
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

DRW

Apoplexy
Internal Haemorrhage +
Leakage of Heart

(duration) yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Haemorrhages + leakage of Heart + Convulsion (duration) yrs. 7 mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr G W Kennard, M. D.

7-31 1922 (Address) 708 Euson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

DATE OF BURIAL Aug 2 1922

20 UNDERTAKER W M Routson

ADDRESS 2235 N ... Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

August 5th, 1922.

* D 66470

Dr. C. Hampson, Jones,
Commissioner of Health,
City Hall, City.

Dear Doctor:-

Pursuant to your kind request for an investigation of the conditions concerning the death of Robert E. Roelke, 1316 W. Baltimore street, for whom a death certificate was filed in this department signed by C. W. Kennard, 708 Ensor street, who stated the cause of death as being due to Apoplexy, Internal Hemorrhage and Leakage of Heart, I beg to report as follows:-

Mrs. Geo. W. Roelke, mother of the deceased, informed me that her son was struck by an automobile three years ago and was injured on the right side of face and head, since which time he had severe pains in the head, tremors at frequent intervals, was speechless for one year and blind for one week before he died. He could walk and his arm movements were normal. No apoplectic symtoms, no hemorrhages, no distortions of facial muscles and his appetite was normal until just before he passed away. She was never told that her son had heart disease.

I beg to advise that in my opinion the death was due to some central injury caused by traumatism.

Respectfully submitted,

Assistant Commissioner of Health.

JFH/vW.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Inemer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66471

CERTIFICATE OF DEATH.

41 D 66471

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Union Memorial Hospital St.. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Inemer

(a) RESIDENCE. No. 3120 Budgewood ave St. Balto WARD. Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6/c yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 1886

7 AGE 36 Years 2 Months 18 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Gary Inemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E. Inemer

(Address) 1547 Myrtle Ave

15 Filed ..... 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to July 31, 1922, that I last saw h.. alive on July 31, 1922, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Septicemia (aureus)

(duration) approx. 3 weeks ds.

CONTRIBUTORY (Secondary) Interstatic abscess liver and peritonitis (duration) yrs. mos. 7 ds.?

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Growth of organisms (cultures)

(Signed) Gordon S. Seagrave, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M & Oliver

DATE OF BURIAL 8/3 192

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mad

AUG 1-1922

PLEASE WRITE PLAINLY WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history.
Dr. Jones phoned to Dr. Laguna

Spec. 1-10-21 MXT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66472

CERTIFICATE OF DEATH.

90 D 66472

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1003 Sharp ST. 23 WARD)

2-FULL NAME Sophie Behrens

(a) RESIDENCE NO. 1003 S. Sharp ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 29 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Conard Behrens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edna M Behrens

(Address) 1003 S. Sharp

15 Filed AUG 1-1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10 1922 to July 31 1922

that I last saw her alive on July 31 1922

and that death occurred, on the date stated above, at 11.55 A. m.

The CAUSE OF DEATH* was as follows

Cardiac Failure

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Valvular heart disease (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. F. Bonn M. D.

7/31, 1922 (Address) 1 E. Randolph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dallo Cem

DATE OF BURIAL: 8/3 19

20 UNDERTAKER: W. Cook

ADDRESS: Sole Nott

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66473

CERTIFICATE OF DEATH.

1177 B 66472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 (Street) Bartlett Av (Ward) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rau E-Magruther

(a) RESIDENCE NO. 706 (Usual place of abode) Bartlett ST. WARD

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Magruther

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
about	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER ? Rhine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) John Magruther 706 Bartlett Ave

15 Filed AUG 1 1922 19 Burial Permit Clerk Registrar

Richardson 1124 25th St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 — 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to July 31, 1922, that I last saw h[illegible] alive on July 31, 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. two mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 31 1922 (Address) 1124 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 8/2 1922

20 UNDERTAKER William Cook

ADDRESS 502 E North

(Goreair)

D 66474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66474

CERTIFICATE OF DEATH.

Registered No. C 113

1-PLACE OF DEATH

City of BALTIMORE: (No. 733-30th St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Goreair

(Residence in Baltimore: No. 733-30th. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

6-DATE OF BIRTH. July (Month) 14 (Day) 1922 (Year)

7-AGE. yrs. mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) ppt

9-BIRTHPLACE. (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER. John Goreara

11-BIRTHPLACE OF FATHER. (State or Country) Italy

12-MAIDEN NAME OF MOTHER. Clara Thomas

13-BIRTHPLACE OF MOTHER. (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Goreara

(Address) 733 30th St

15-

Filed 1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 1 (Month) 2 (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

In Located Rickets

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

1922 (Address) 143 E Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Cemetery DATE OF BURIAL. 8/2 1922

20-UNDERTAKER. George J. Ruth ADDRESS 1735 Hanford Ave

Remarks: Intestinal indigestion.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

WRITE PLAINLY. With pen and ink. Lead pencil will not be accepted. AGE should be stated EXACTLY. PHYSICIANS MUST
N. B.—Every item of information should be carefully supplied. A
state CAUSE OF DEATH in plain terms, so that it may be
is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66475

CERTIFICATE OF DEATH.

D 66475

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore Car Works. St., Curtis Bay. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Vogel.

(Residence in Baltimore: No. 1219 William St. St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. April 30, 1856. (Month) (Day) (Year)

7-AGE. 66 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of Industry, business, or establishment in which employed (or employer): O

9-BIRTHPLACE, (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. John Vogel.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Caroline ----.

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Vogel.(wife).

(Address) 1219 William St.

15-

Filed ..... 19.. Robert P. Harrison, Registrar.

AUG 14 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 31st. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) [signature] M. D. (Coroner.)

Aug. 1st 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. 8/3 19..

20-UNDERTAKER. [signature] ADDRESS 1318 Eutaw Pl.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66476

CERTIFICATE OF DEATH.

D 66476

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 S Catherine ST., 10 WARD)

2-FULL NAME George J Saffran

(a) RESIDENCE NO. 127 S. Catherine ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) May 1 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Saffran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Gen Augl

13 BIRTHPLACE OF MOTHER (city or town) Mcca (State or country) Balto, Md

14 Informant Clara S. Saffran (Address) 127 S. Catherine

15 Filed .....19..... ROBERT R. KRAUTER, Registrar

AUG 2 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 22

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 ,19 21 , to July 31 ,19 22 ,

that I last saw ~~him~~ alive on July 31 ,19 22

and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Carcinomata of Stomach

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Observation

(Signed) Robert C Ritsch M. D.

Aug 1 ,19 22 (Address) 2151 Sullivan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Aug 3 19 22

20 UNDERTAKER Geo W. Tittle — ADDRESS 27 W Edmonson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 66477
Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 129 N Dallas St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addison Gray

(Residence in Baltimore: No. 129 N Dallas St.; yrs., 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.): Married

6-DATE OF BIRTH: ..... 1..... (Month) —— (Day) ——(Year)

7-AGE: 44 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country): Va. Caroline Co.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife Maria Gray

(Address) 129 N Dallas

15- Filed AUG 2 - 1922 192 ROBERT R. KRAUTER, Burial Permit Officer.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 31 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Gastritis,
Enterocolitis

(Duration) ....yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ....yrs. mos. ds.

(Signed) Geo Clinton Bailey M.D.
(Coroner)
Aug 1 192 (Address) 163 Fairmount Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Arbutus Cemetery	Aug 2 1922
20-UNDERTAKER	ADDRESS
Mrs Robert Allen	1725 Portland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

15 66478
D 66478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100,001 D 66478

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Steward.

(a) RESIDENCE No. 2611 Boone St. City. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ or ~~WIFE of~~: Annie Steward Mother

6 DATE OF BIRTH (month, day, and year): July 26, 1921

7 AGE: Years 1 Months — Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child, 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Luther Steward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Annie Spouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL, Records (Address)

15 Filed AUG 2 - 1922 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1922, to July 30, 1922, that I last saw her alive on July 30, 1922, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

md

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? x-ray

(Signed) T B Gay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery | DATE OF BURIAL: Aug 2 1922

20 UNDERTAKER: Mrs Robert A Elliott | ADDRESS: 1729 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

D 66479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66479

CERTIFICATE OF DEATH.

Registered No. C 199

1-PLACE OF DEATH

City of BALTIMORE: (No. Warner & Henrietta Sts. St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eveline Williams (C)

(Residence in Baltimore: No. 725 Sterling St. St.; yrs. 16 mos. 10 ds. 21)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female.	Colored	Single

6-DATE OF BIRTH. September 10th. 1905
(Month) (Day) (Year)

7-AGE. 16 yrs. 10 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS

10-NAME OF FATHER. Andrew Williams (C)

11-BIRTHPLACE OF FATHER (State or Country). Pennsylvania.

12-MAIDEN NAME OF MOTHER. Laura Parker. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Williams. (C) father.

(Address) 725 Sterling St.

15- Filed AUG 2-1922 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 21st. 1922.
(Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull & laceration of the brain. Automobile recklessly driven against a lamp post.

Homicide. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [signature] M. D. (Coroner.)

Aug. 2 192 2. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel

DATE OF BURIAL. aug. 2nd 192 2

20-UNDERTAKER. mrs. B. a Elliott

ADDRESS 1925 Ashland Ave

Spec. 1-10-21 M&T 1500 Bks.

Gilbert Leuba

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-B 66480

D 66480

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Bolton ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gibolt Leuba

(a) RESIDENCE No. 1213 Bolton ST., WARD ....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1922

7 AGE Years ... Months ... Days 2 LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER August Leuba

11 BIRTHPLACE OF FATHER (city or town) Buttes (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Erickson

13 BIRTHPLACE OF MOTHER (city or town) Montairy (State or country) Maryland

14 Informant August Leuba

(Address) 1213 Bolton Bal. Md.

15 Date AUG 2 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1922

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1922, to Aug 1, 1922

that I last saw him alive on July 31, 1922

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. F. Blackamore M. D.

8/2, 1922 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL—CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: 8/2-1922

20 UNDERTAKER: Wm. J. Tickner & Son — ADDRESS: Bennett Place